



# **Domestic Homicide Review**

## **Safer Ealing Partnership**

### **Case of Rose**

**Independent Chair Victoria Hill  
November 2015**

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# Introduction

## Details of the incident

- 1.1 At 01:32hrs on the 13/03/2012 Rose called the London Ambulance Service (LAS) and said “my partner has stabbed me”. A Fast Response Unit, two ambulances, a Hazardous Area Response Team vehicle and a senior officer were dispatched between 01:37hrs and 01:54hrs, arriving between 01:47hrs and 02:08hrs at the perpetrator’s (Peter) address. The Metropolitan Police arrived on the scene first at 01:37hrs, followed by the LAS. At the scene, the Police were confronted by Peter who was in possession of a knife. Rose was lying on the floor with stab wounds. Peter was asked to put the knife down which he failed to do. The Police officers deployed their CS spray twice which had no effect on him. Peter then stabbed Rose again in front of the Police officers and he was wrestled to the ground by the officers. Peter was then arrested for the murder of Rose.
- 1.2 Rose’s life was pronounced extinct at 03.09hrs.
- 1.3 In July 2013, Peter was detained indefinitely for the manslaughter of Rose under section 37/41 of the Mental Health Act (1983).

## The review

- 1.4 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Safer Ealing Partnership (SEP). The SEP is the Community Safety Partnership (CSP) in the London Borough of Ealing.
- 1.5 Following Rose’s death, the SEP requested the review to commence in April 2012 and an independent chair was appointed in May 2012. The first panel meeting took place on 03/07/2012. Due to delays experienced in convening the panel, the original independent chair of the review then decided to resign on 08/02/2013.
- 1.6 Following this, the SEP had to restart the review again and approached Standing Together Against Domestic Violence to chair the review in March 2013. Please refer to the section: *Delays with the DHR* on page eight for more detail about this.
- 1.7 Standing Together were commissioned to chair the review and the initial meeting of the reconvened review was held on 15/05/2013. There have been six subsequent meetings of the DHR panel to consider the circumstances of this death.

- 1.8 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.
- 1.9 The purpose of these reviews is to:
- 1.9.1 Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
  - 1.9.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
  - 1.9.3 Apply those lessons to service responses including changes to policies and procedures as appropriate.
  - 1.9.4 Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working
- 1.10 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

### **Terms of reference for the DHR**

- 1.11 The full terms of reference are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future. The review used the original terms of reference agreed for the original review commenced in 2012.

### **Review methodology (including family contact)**

- 1.12 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Rose or Peter. IMRs included chronologies for contact in the period agreed by the panel for the terms of reference.
- 1.13 The time period subject to the review was 01/01/1993 – 13/03/2012. 1993 was chosen as the start date for the chronology as this is when Peter's mental health concerns are first recorded.
- 1.14 It was also considered helpful to involve agencies that could have had a bearing on the circumstances of this case, such as local domestic violence services, even though they were not previously aware of the individuals involved.

- 1.15 Once the IMRs and chronologies had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.
- 1.16 No other parallel reviews have been conducted<sup>1</sup>.
- 1.17 Rose and Peter between them had four adult children. They were all contacted by the chair to see if they would like to be involved in the review. The chair has had brief contact with one of Rose's sons, who subsequently decided not to engage further with the review. One of Peter's daughter's has spoken at length on several occasions with the chair and has also met with the chair to review the draft report.

### **Composition of the DHR panel**

1.18 Agencies and services represented:

- Metropolitan Police – Ealing borough and Critical Incident Advisory Team
- Ealing Council – Safer Communities Team
- Ealing Council – Noise Nuisance Team
- Ealing Council – Public Health<sup>2</sup>
- Ealing Council – Tenancy Management and Landlord Services (including Housing Repairs Service)<sup>3</sup>
- NHS England (representing General Practice Ealing)
- NHS Ealing Clinical Commissioning Group (CCG)
- West London Mental Health NHS Trust
- Ealing Hospital NHS Trust
- Imperial College Healthcare NHS Trust (St Mary's Hospital)
- Southall Black Sisters
- Hestia Housing
- Victim Support
- Housing for Women
- RISE (drug and alcohol service)
- Standing Together Against Domestic Violence (chair and administration).

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<sup>1</sup> The circumstances of Rose's death were not referred to the Independent Police Complaints Commission

<sup>2</sup> Ealing Council Public Health did not attend any panel meetings but were included in the distribution of all the papers.

<sup>3</sup> This was previously Ealing Homes, an Arms Length Management organisation, responsible for social housing.

A full list of panel members is contained in Appendix 2.

- 1.19 The independent chair of the DHR is Victoria Hill, an associate consultant working for Standing Together Against Domestic Violence, an organisation dedicated to developing effective, coordinated responses to domestic abuse.
- 1.20 Victoria Hill has fifteen years experience of working in the domestic violence sector and has no connection to the London borough of Ealing or with any agency involved in this case.

## **Overview of health services in the London Borough of Ealing**

- 1.21 Due to the complexities of the health services mentioned in this review, a brief overview of each organisation is provided below for the reader:

### **1.22 NHS England**

The NHS England is an executive non-departmental public body. It works under its mandate from the Government to improve the quality of NHS care and health outcomes, reduce health inequalities, empower patients and the public and promote innovation. Its key responsibilities include:

- 1.22.1 Authorisation and oversight of Clinical Commissioning Groups and support for their on-going development.
- 1.22.2 The direct commissioning of primary care, specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships).
- 1.22.3 Developing and sustaining effective partnerships across the health and care system.

### **1.23 NHS Ealing Clinical Commissioning Group (CCG)**

- 1.23.1 Clinical Commissioning Groups are new statutory organisations created on 1 April 2013 by the Health and Social Care Act 2012. They plan, commission and monitor a wide range of health services for patients.
- 1.23.2 Every GP practice in Ealing is a member of the Ealing Clinical Commissioning Group which is part of the Central London/West London/Hammersmith and Fulham/Hounslow/Ealing Clinical Commissioning Groups Ealing Clinical Commissioning Groups Collaborative (CWHNE CCGC). CWHNE CCGC is responsible for planning and paying for services within the area. This includes:

planned hospital care such as operations, rehabilitation services, urgent and emergency care and most community services. Ealing CCG is also responsible for engaging with local people to ensure that the services they are paying for meet their needs.

#### **1.24 Ealing Hospital NHS Trust**

1.24.1 The Integrated Care Organisation was established in April 2011 and comprises of Ealing Hospital (district general hospital), Ealing Community Services, Harrow Community Services and Brent Community Services all of which form Ealing Hospital ICO NHS Trust.

1.24.2 The Ealing Hospital acute site has over 350 beds, with a further 160 beds in the community service sites. These include Willesden Hospital in Brent, Clayponds Hospital and Meadow House Hospice in Ealing and Denham Intermediate Care Unit in Harrow.

#### **1.25 Imperial College Healthcare NHS Trust (St Mary's Hospital)**

1.25.1 Imperial College Healthcare NHS Trust is a large acute hospital trust. The Trust consists of Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye Hospitals.

1.25.2 The consultant hepatology clinics are facilitated at Hammersmith and St Mary's Hospitals. The liver & anti-viral unit is based at St Mary's Hospital and it manages patients on Hepatitis C treatment.

#### **1.26 West London Mental Health NHS Trust**

1.26.1 WLMHT is the provider of mental health services to the London Borough of Ealing, Hammersmith and Fulham and Hounslow. The organisation provides a wide range of mental health services to adults and children.

1.26.2 WLMHT does not currently provide specialist substance abuse treatment but did provide psychosocial treatment for such problems at some community mental health teams. Specialist and inpatient services are provided by another organisation: Central and North West London Mental Health NHS Trust (CNWL).

1.26.3 As well as community and inpatient mental health services, WLMHT is a leading national provider of forensic (secure) and specialist mental healthcare. The specialist services include:

- Broadmoor Hospital - one of only three high security mental health hospitals in England.
- The Cassel – a specialist inpatient service for people with personality disorders.
- The Gender Identity Clinic –the leading provider of care for people who have issues around their gender.
- West London Forensic Services - providing mental healthcare in low and medium secure environments.

## **Delays with the DHR**

- 1.27 This review has encountered unacceptable significant delays, which has potentially compromised the purpose and the integrity of the review (particularly with the families of Rose and Peter). It is particularly concerning that the delays have no doubt impacted on the review's ability to expedite learning and ensure that improvements to the response to domestic violence are implemented as soon as possible so to help prevent similar events from happening to others.
- 1.28 The first review was convened by the Safer Ealing Partnership, who selected an independent chair to guide them through the process of the DHR. This review failed to achieve momentum, and there is acceptance from the Council's lead department (Safer Communities) that with this being their first review they had underestimated the time and resources necessary to support such a process. The chair of the review tendered their resignation and arrangements were made for the appointment of a new independent chair.
- 1.29 Standing Together were commissioned in May 2013 to chair the review, and based on their experience of other similar reviews recommended and offered to provide the coordination and administrative function to support the process. Standing Together commenced the review (and coordination/support of the same) immediately following their commission.
- 1.30 The reconvened review has unfortunately experienced on-going difficulties in identifying the appropriate agencies and representatives to engage with the review, and there have been delays by some agencies in the production of their IMRs.
- 1.31 Further delays were encountered in obtaining the IMRs, notably from Rose's and Peter's GP. Changes to the NHS in April 2013 meant that it was unclear who was formally responsible for commissioning the IMR from the GP. The Home Office DHR Statutory Guidance makes it clear that the IMR must be provided by someone who has not provided care to the individuals concerned (or supervised those that have). This added a delay of over two months to the review and the depth of information included in the IMR has also unfortunately limited the rigour of analysis of the review in regard to the victim's and perpetrators contact



with their GP. The issue of securing GP IMRs has been included as this is a fundamental block for all DHRs.

- 1.32 Following review of the IMR submitted by Peter's GP, an additional IMR was then required from Imperial College Healthcare NHS Trust (St Mary's Hospital) to obtain information on his Hepatitis C treatment. Submission of the IMR was then subject to further delays due to their internal quality assurance process.

## The Facts

### Rose's death

- 2.1 At 01:15hrs, on 13/03/2012, a neighbour of Peter heard a loud disturbance and a woman scream three times. They heard what they believed to be crockery smashing and looked out of their window to see where the noise was coming from.
- 2.2 The same neighbour then heard banging and saw Peter in his property. He was holding a large black handled knife in his right hand and was banging the handle on the frame of his window. He looked directly up at the neighbour and said "Call me an ambulance, someone has died here".
- 2.3 At 01:32hrs, Police were also called to Peter's address. The caller (Rose) told the operator that her boyfriend had stabbed her, that his name was Peter, and that she was on the floor in the kitchen. The London Ambulance Service (LAS) were also requested.
- 2.4 On Police arrival, four Police officers went up the stairs to the third floor flat and knocked on the door, which was closed, stating 'Police, open the door'. A few seconds later the door was opened by about an inch. Police pushed the door open where they saw Peter standing at the end of the hall next to the kitchen holding a large black handled knife in his hand. They saw Rose who was in a dressing gown lying on the kitchen floor on her back, with her head propped up on a cupboard door near the sink and her feet pointing towards the front door. She was obviously wounded, bleeding heavily and she told the Police officers 'Help me I need an ambulance'. She was still talking on the phone to the Police operator when Police arrived.
- 2.5 The Police instructed Peter to put the knife down on a number of occasions, but he refused. He walked backwards and forwards from the sitting room, bedroom and back to the hall. At

one stage he had put the knife down in another room<sup>4</sup>; however, when Police approached Peter he quickly ran to the room and re-armed himself. The officers sprayed Peter with CS gas twice, and this appeared to have no effect. Peter then ran into the kitchen and in front of the officers, leant over Rose and stabbed her once more in the side of her stomach. After a struggle, using batons, the officers were able to disarm Peter and tried to assist Rose, who was bleeding badly from several knife wounds.

*(To assist the reader a map of Peter's address is included in Appendix Four of the report.)*

- 2.6 On the arrival of the LAS, Rose was taken to St Mary's Hospital, Paddington. Her life was pronounced extinct at 03:08 hrs.
- 2.7 Peter was arrested for Attempted Murder whilst at the scene. He told officers that 'the BBC made him do it' and 'it's the BBC's fault'. He was further arrested for Murder when in custody at Acton Police Station. He made no comment to this charge.
- 2.8 A special post-mortem was held on 13/03/2012. Rose's cause of death was multiple stab wounds to the chest. Rose had sustained several stab wounds to her shoulder, abdomen, chest, legs and side but the main chest wound had pierced her aorta. She had very few defensive injuries. She had a black eye and various bruises on her arms.

## **Sentencing Peter**

- 2.9 Peter pleaded guilty to the manslaughter of Rose under diminished responsibility in December 2012. On 10/07/2013, he was sentenced at the Central Criminal Court to a Hospital Order with restrictions, to be detained indefinitely under Section 37/41 of the Mental Health Act (1983) for purposes of public protection.
- 2.10 At the sentencing hearing, the Judge said that the behaviour of the Police officers at the scene was exemplary and commended the officers for their bravery, skill and courage in tackling Peter and attempting to save Rose's life.

## **The perpetrator**

- 2.11 Peter admitted to stabbing Rose five times before the Police arrived and then further admitted stabbing her in front of the officers. He stated that he had stopped taking medication for his Hepatitis C condition about one week before the incident as it made him

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<sup>4</sup> The officer's statements were re-reviewed to clarify what rooms Peter moved between. Events unfolded very quickly and none of the officer's statements clarify which room he was walking in and out of. On examination of the map of Peter's property (Appendix Four) alongside the officer's statements it would seem that the police officers were at the front door/just into the hallway of the flat, and were about 6 or 7 feet away from Peter, who was facing them but down along the corridor more towards the door of the lounge and kitchen. Although none of the officers say which room this was, it would either be the bedroom or lounge/sitting room.

feel strange. He stated that he did not know why he attacked Rose, that he could not remember Rose arriving at the flat or what they did prior to the incident (although he said he thought that they had watched television). He stated he heard abusive voices in his head; although, they did not tell him to do anything specific.

- 2.12 Peter has not had any convictions prior to this incident since 1994. Peter had an alleged history of domestic violence. He also had a recorded history of violence offences of varying degrees of severity (including a stabbing) dating back to 1978.
- 2.13 Although it is not within the time frame subject to this review, in 1989 Peter was sentenced to three years imprisonment for Grievous Bodily Harm with intent, after he used a kitchen carving knife to attack a man (to whom he owed money to). The victim was stabbed twice in the left arm, once in the chest and was slashed across the face causing injuries requiring thirty stitches.
- 2.14 There were allegations of previous violent conduct towards Rose, his own children and also Rose's children.
- 2.15 Peter had a previous history of Class A drug use (intravenous use of heroin), alcohol use and fluctuating mental health.
- 2.16 Peter declined to engage in the review.

### **Peter's mental health diagnosis**

- 2.17 Peter's historical contact with mental health services show some diagnostic uncertainty, but a working diagnosis of paranoid schizophrenia complicated by substance use was originally made by WLMHT.
- 2.18 It would appear that Peter has had episodes of drug induced psychosis over the years.
- 2.19 At time of review, Peter was diagnosed with Dissocial Personality Disorder (otherwise known as antisocial personality disorder) complicated by a history of drug induced psychosis. An explanation of Peter's diagnosis from WLMHT is provided below:
- 2.20 Individuals with Dissocial Personality Disorder have enduring problems with impulsive, conflict seeking behaviour. They fail to profit from experience and have a persistent disregard for rules, laws and the rights of others. It is not uncommon for such individuals to be involved in criminal activity. Those with dissocial personality disorder have significant problems tolerating frustration and delaying gratification. This often leads to angry or violent outbursts. People with dissocial personality disorder often have relationship difficulties. They

are able to form relationships but these are often characterised by conflict, and usually end after running a turbulent and short course.

2.21 Drug induced psychosis describes periods of psychotic symptoms in the context of drug use, most commonly cannabis, cocaine or amphetamines. Such symptoms might be very similar to schizophrenia and include hallucinations (abnormal false perceptions) and delusions (abnormal false fixed beliefs). Individuals with drug induced psychosis might have psychotic symptoms for several weeks or even months, but there is a clear link to drug use at the same time and after time. Symptoms respond to treatment or pass with time.

2.22 At Peter's sentencing hearing, it was stated that a long term prognosis could not be made of his progress, and that since he had been detained there had been little progress in his mental health improving.

### **Peter's and Rose's relationship**

2.23 The Police information states that the couple were in a relationship for about nineteen years. At Peter's sentencing hearing it was stated that they were together for fourteen years. The Police IMR stated (which was confirmed by Peter's eldest child - Tina) that about sixteen years ago, Rose and Peter lived together with all of their four respective children. They had never married.

2.24 Prior to Rose's death, they were living at separate addresses and this arrangement appears to have suited them both. It has been described by one of Peter's children (Tina) that Peter's relationship with Rose had changed to where she had become more of a carer to her father than being his girlfriend. In October 2010, Rose described Peter to her GP as her ex-partner.

# Contact with agencies and services

3.1 Neither the victim nor perpetrator were known to the following services:

- Southall Black Sisters
- Hestia
- Housing for Women
- Central and North West London NHS Foundation Trust (including Gatehouse Services and CRI Treatment Services)
- RISE - Recovery Interventions Service Ealing<sup>5</sup>.

## Metropolitan Police

3.2 There is a brief reported history to the Police surrounding domestic violence between Rose and Peter of three non-crime domestics. There were also domestic violence incidents which were reported to the Police involving Peter and the four children. The domestic violence incidents are listed below.

3.3 Peter's history of domestic violence:

3.3.1 In 1993, Peter's ex-partner made an allegation of assault to the police. She stated that Peter had used a table leg to hit her and that he grabbed her causing injuries to her arms. Peter was charged with Actual Bodily Harm and was found not guilty at Ealing Magistrates Court on 14/10/1993.

3.3.2 In 1997, Emma (one of Peter's children) made an allegation during a social services visit, that Peter had assaulted her by pulling her off the sofa by her hair, punching and kicking her around the body. This incident apparently happened when Peter came home after drinking alcohol and had an argument with Emma about her poor school attendance. He suspected that Emma and her sibling (Tina) were talking to social services in order to leave home. During the incident, Peter was alleged to have verbally abused Emma and caused carpet burns to her leg when he dragged her off the carpet.

3.3.3 Social services immediately housed Emma following this disclosure. Peter admitted to slapping Emma, but denied punching and kicking her. A doctor had examined Emma and noted a cut lip, red mark above her eyelid and a carpet burn to her leg. Emma declined to assist any further with any investigation as she did not want to give evidence in court. In light of the evidence available, and the unwillingness of Emma to assist any further investigation, this matter was cleared up under Home Office Rule

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<sup>5</sup> RISE have confirmed that Peter was never referred to the in house alcohol service which was operating at his GP surgery.

8<sup>6</sup> and no other action was taken.

3.4 First reported domestic incident between Rose and Peter:

3.4.1 On 04/01/1998, Peter was staying at Rose's address and had been depressed due to his two daughters not living with him. Whilst at the address, he locked himself in the bedroom after Rose left the premises to go to see her mother. During her absence, Peter smashed the bedroom windows and began to throw furniture (including a TV) and clothing out of the windows. Police arrived and he removed the barricade to the door and allowed them inside.

3.4.2 He was arrested for criminal damage and breach of the peace; however, Rose did not wish to substantiate any allegation. A withdrawal statement was taken and Peter was released with no further action being taken. The case was shown as a Home Office clear-up using Rule 8.

3.5 Reported incidents of domestic violence between Peter and Rose's sons:

3.5.1 On 08/03/2003, Matthew (son of Rose) made an allegation that Peter had threatened him with a knife. Rose stated that her son and Peter did not get on with each other. Matthew was intoxicated and had come home drunk and had started to shout abuse at Peter, who was in the kitchen doing the washing up.

3.5.2 Rose stated that at no time did Peter threaten Matthew with a knife. This was latterly confirmed by Peter and Matthew. Matthew was told to leave the property to prevent a breach of the peace and no further Police action was taken.

3.5.3 Three weeks later on 29/03/2003, Matthew alleged that Peter had punched him in the face twice during an altercation where Matthew was trying to get into Peter's bedroom. Matthew had slight reddening to his face. He declined to assist the Police any further with the allegation and no further Police action was taken.

3.6 Second reported domestic incident between Rose and Peter:

3.6.1 On 16/06/2003, a domestic incident was reported to the Police by Rose stating that Peter was refusing to leave her address after they had an argument whilst he was drunk. Police attended the address and on speaking to Rose they were told that Peter had left the premises already. There were no other offences disclosed at the time. Rose stated that Peter was drunk but he had not physically assaulted her. This

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<sup>6</sup> Home Office rule 8 - A crime is 'cleared up' (known as a detected crime) when the guilt of the offender is clear but the victim refuses, or is permanently unable or if a juvenile is not permitted to give evidence.

was recorded as a non-crime domestic incident.

3.6.2 The Police advised Rose to call then again if Peter returned to the address. A follow-up call was made to her by the Police Community Safety Unit two days later, and Rose confirmed that there had been no reoccurrence of any problems.

3.6.3 There are no Police records of incidents between the couple between 16/06/2003 and 11/02/2010.

3.7 Third reported domestic incident between Rose and Peter:

3.7.1 A third party made a report to the Police of a domestic incident on 11/02/2010. They stated that they could hear a woman screaming for help. Police attended the address and spoke to Peter who was alone at the address. Peter was described as being drunk. The Police informed him that they had received a report of a woman screaming and asked if they could search the address, which he allowed. The premises were empty. The officers then left but returned a short while later as the anonymous informant stated that the woman involved had walked past the Police and had been on a mobile phone. Police again spoke to Peter who confirmed after several minutes that Rose had been there but was adamant that nothing had occurred. Peter thought that the officers were 'having him on', but he provided them with Rose's mobile number (which the Police tried but got no answer).

3.7.2 There was no evidence of any disturbance or offences at the address. The Police made some attempts to contact Rose but the phone number they were given appeared to be turned off. A CAD (Computer Aided Dispatch) message was created to ensure a follow-up call was made to her address to ensure she was OK. Officers attended Rose's address the following day, but she was not there. An occupant was spoken to but could not confirm her whereabouts. Police further attended the address and after several days they established from a neighbour that Rose had been seen and there was no concern for her welfare. In the absence of any offences, this matter was recorded as a non-crime domestic incident.

3.7.3 Rose had no previous convictions.

## **General Practice Ealing**

3.8 Rose and Peter were registered with different practices.

3.9 Rose had been registered with her GP since 1993. She was seen regularly and there was no evidence of domestic violence in her record or any mention of her partner. She attended

most frequently between 2006 and 2010 in relation to a serious health condition. During these numerous contacts, it is not recorded whether she was asked about domestic violence (or disclosed it) or whether she was offered or requested support about her home life or her relationship with Peter.

- 3.10 Rose saw her GP in July 2009 about a fall having injured her right shoulder and arm, and then again in July 2010 following another fall where she hurt her left foot. The similarity of these injuries was not considered nor was the potential of conducting a clinical enquiry for domestic violence. No disclosure of domestic violence is recorded.
- 3.11 In October 2010, Rose saw her GP for a blood test stating that her ex-partner has been diagnosed with Hepatitis C. There is no other detail in the records about this.
- 3.12 Peter had been registered with his GP since 2007. The IMR stated that his notes contained a summary of his care at previous practices going back to 1993, but these did not suggest a history of domestic violence. His records showed drug overdose, mental health concerns and alcohol abuse with several admissions in 1993. The summary appears not to have significantly detailed Peter's previous mental health issues. There was no diagnostic code on the GP record of WLMHT's diagnosis of Peter mental health.
- 3.13 Peter's alcohol use is recorded in his GP records but there is no record of a referral made to a community drug and alcohol service.
- 3.14 He attended the practice twenty-seven times since April 2007. This was not deemed to be unusual and the higher number of consultations in 2011 (eight) related to his on-going treatment for obesity and unrelated physical health issues.
- 3.15 The chronology for Peter's GP contact offers very little detail; however, on 26/03/2008 he saw his GP and was given information on sexually transmitted infections (this was standard safe sex advice from his GP given his previous exposure to Hepatitis B and intravenous drug use). In relation to the safe sex advice there was nothing noted regarding his partner. In September 2010, the chronology details Peter's Hepatitis C diagnosis. Here it is stated that he had not injected drugs for more than ten years, but his alcohol intake is not documented. He is advised to use condoms but again there is no specific mention on his partner.
- 3.16 On 19/11/2010, the GP suggests to Peter that his partner should attend for a Hepatitis B vaccination. In April 2011, suspected cirrhosis<sup>7</sup> is documented and he is told by his GP to

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<sup>7</sup> Cirrhosis is scarring of the liver as a result of continuous, long-term liver damage. Scar tissue replaces healthy tissue in the liver and prevents the liver from working properly.



avoid alcohol. The records state that on 03/08/2011 Peter reports he was due to start his antiviral treatment for Hepatitis C and that he had stopped drinking alcohol.

- 3.17 Three days after Rose's death, Peter's specialist hepatology nurse contacted the GP to state that Peter had failed to attend an appointment, and that she was concerned as he had previously complained of feeling depressed (but not suicidal). This is the first recorded evidence of mental health concerns in his file since 1993.

### **West London Mental Health NHS Trust**

- 3.18 Peter had contact with WLMHT in 1993 and 1998. Peter was not a client of WLMHT at the time of Rose's death. There is reference in Peter's notes of contact with mental health services in the West Midlands and in Bournemouth, but there are no further details available about this.
- 3.19 Peter's first contact with WLMHT was between 03/09/1993 and 15/09/1993 after he had been found in a fast food restaurant's toilet having taken an overdose of 60 x 20 mgs of Temazepam<sup>8</sup> and injected 200 mgs Temazepam twenty-four hours previously. Peter was admitted to hospital and diagnosed with opiate dependence and drug problems.
- 3.20 Peter stated that he had been planning to kill himself for the last year and had made four attempts. He also stated that he had been admitted into hospital in Bournemouth for an episode of depression (no further details about this are available).
- 3.21 As stated previously on page nine (Peter's mental health diagnosis), Peter had at this time a working diagnosis of paranoid schizophrenia complicated by substance use.
- 3.22 During this contact with mental health service, Peter was homeless. He was referred to local drug services and the local Homeless Persons Unit. The letter sent to the Homeless Person Unit requested he be considered a vulnerable adult (due to his mental health and opiate dependency) under the Housing Act to help him access accommodation as he was on no fixed abode.
- 3.23 The outcome of referrals to the local drug service and the Homeless Persons Unit are not known. During his assessment, concerns about the potential for domestic violence were not specifically raised. Peter discharged himself against medical advice. At that time, he was considered not to have mental health problems.

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<sup>8</sup> Temazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative and anxiety-relieving effects.

- 3.24 On 04/12/1995, Peter was referred to community drug and alcohol services at Cherington House, WLMHT by his probation officer as part of his probation order. The records do not detail the extent to which the probation officer was involved. He disclosed having problems with binge drinking and had done so for a few years. He did not show any signs of mental illness but was diagnosed with having alcohol problems (but not addiction to alcohol).
- 3.25 Despite being subject to probation supervision and being directed to attend appointments, Peter had intermittent engagement with the service. His motivation to change his drinking was limited. At times, Peter complained of family problems although the nature was not fully explored. One of his daughters (not named) attended some appointments with him. He was eventually discharged from Cherington House on 26/06/1997 following non-attendance at a number of appointments.
- 3.26 Peter's second contact with WLMHT took place following his transfer from a psychiatric hospital in Devon, following an incident at his mother's house where he barricaded himself in a room. He had contact with mental health services in Devon between 16/03/1998 and 31/03/1998. Peter had been brought to hospital by the Police pursuant to Section 136 Mental Health Act 1983 and subsequently detained under Section 2 (inpatient assessment) at The Edith Morgan Unit, Torbay Hospital.
- 3.27 The WLMHT records state that one of Peter's previous partners (not Rose) indicated that he had been violent to her on one occasion whilst unwell and under the influence of drugs in 1998. She was interviewed by staff but did not disclose "any other incidents of regular domestic violence". There is no further information of what this comment meant or what questions was actually asked and how the enquiry was conducted with her. From review of other chronologies and information from one of Peter's children, it is considered that this person was in fact Rose.
- 3.28 It is also stated that his girlfriend (believed to be Rose) had noticed some behaviour changes such as driving on the wrong side of the road at high-speed to test if she was being unfaithful, held a knife to her throat and cut TV cables as these forms of communication were spreading rumours about him.
- 3.29 There is no evidence of consideration of the risks posed to the partner concerned (thought to be Rose) and what support was offered to her.
- 3.30 On admission to WLMHT on 16/03/1998, when Peter was approached by a nurse he lashed out and smashed a double locked fire door and was restrained and put in seclusion and was

treated with intramuscular Droperidol<sup>9</sup>. He was unwell and demonstrated psychotic symptoms in the context of drug use. It was considered that he might have a drug induced psychotic episode or schizophrenia. Later it was concluded that Peter had schizophrenia.

- 3.31 As Peter was a resident of the London Borough of Ealing, he was referred to local mental health services at WLMHT. Peter was behaviourally settled and demonstrated some insight into his difficulties. According to the notes, his symptoms resolved within days. The diagnostic consensus was one of schizophrenia. He had been detained pursuant to Section 2 Mental Health Act 1983 and in accordance with his rights, he applied for discharge from hospital via Mental Health Review Tribunal. According to the files, Peter indicated willingness to the team that he would comply with community care and follow up and agreed to remain in hospital on a voluntary basis whilst such arrangements were being made.
- 3.32 The Mental Health Review Tribunal rescinded the decision that Peter should be detained under the Mental Health Act and contrary to his assurances he gave throughout the tribunal, Peter then took his own discharge against medical advice. He was provided with medication and an appointment was made with Dr C, Consultant Psychiatrist at Cherington House Community Mental Health Team (CMHT). Peter self-discharged from hospital on 08/04/1998.
- 3.33 Peter was offered follow up by the Cherington House CMHT. An appointment was made for him on 06/05/1998 but he did not attend. A further appointment was offered to him for 01/06/1998, but again he did not attend. Peter's GP, at that time, was contacted by telephone and according to the files, Dr C was informed that Peter was seeing a doctor 'down the coast'. Peter was subsequently discharged. According to available notes, this was the last contact with WLMHT before the homicide.
- 3.34 It has been suggested that telephone contact was made by family members or by Peter with WLMHT in the time leading up to the incident, but no records of such contact exists and the full details are not known.
- 3.35 Neither Rose nor any of their children had contact with WLMHT. During Peter's previous contact with WLMHT, his children were known to Children's Social Care but they were not living with him at the time of this contact.

### **Imperial College Healthcare NHS Trust (St Mary's Hospital)**

- 3.36 Peter was referred to St Mary's Hospital Hepatology Clinic by his GP for treatment of Hepatitis C. Hepatitis C is a serious health condition. It is a virus that can infect and damage

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<sup>9</sup> Droperidol is a sedative drug (now withdrawn from use in Europe).

the liver. The virus is transmitted through blood to blood contact or, less commonly, through body fluids of an infected person. In most cases, Hepatitis C causes no noticeable symptoms until the liver has been significantly damaged.

- 3.37 On 07/09/2010, Peter was referred by his GP and he attended his first appointment on the 26/10/2010. Peter completed twenty-two weeks (out of twenty-four) of treatment. He was compliant with his continued need for injection supervision. He had twenty-one appointments whilst on the treatment. He had weekly appointments and this is noted to be considerably above the routine appointments required for his treatment course due to his difficulties with self-administering the injections.
- 3.38 During Peter's clinic attendance for Hepatitis C treatment, Peter showed no signs of mental health deterioration. He reported abstinence from illicit substances and did not present to clinic intoxicated.
- 3.39 Peter was referred to the clinical nurse specialist team on 29/03/2011 for assessment and was seen on 19/07/2011.
- 3.40 The lead in time to treatment is slow due to the nature of the tests and assessments patients have to undergo. It has been confirmed that it is usually a sixteen week lead in time to treatment and the period of time Peter experienced from referral, assessment and treatment was not unduly delayed.
- 3.41 The assessment documentation Peter underwent has a section specifically for mental health, depression and harm-to-self. Peter self-disclosed a past history of depression which was being treated with Prozac. Peter also reported an episode of self-harm, because "he felt like it" whilst on this medication. No other information was self-disclosed on questioning Peter at that time regarding his previous mental health issues.
- 3.42 On 29/03/2011, Peter attended the clinic with Rose. It is usual practice that family members and friends are invited and encouraged to attend clinic meetings so that they can answer questions and understand the impact that anti-viral treatment may have on their relationship due to the powerful side effects of the medication. General lifestyle advice was given.
- 3.43 After consideration of his clinical care options, Peter chose to undertake treatment and attended for screening tests on 29/09/2011. At this time, Peter was transferred to the care of a nurse experienced in taking samples due to extreme difficulty Peter had with accessing blood. He commenced anti-viral therapy for Hepatitis C on 13/10/2011. Peter's prescribed medication was Peginterferon alpha 2B (ViraferonPeg) subcutaneous injections 150mcg

every Thursday and Ribavirin (Rebetol) capsules 600mg twice daily. Peginterferon is documented to induce a number of psychiatric disorders.

- 3.44 Patients of the clinic receive a full description of the side effects and risks involved in their treatment. The nurse treating the patient then picks out the specifics in the history obtained through the assessment and matches it to the side effects of the medication being prescribed to target what will create problems. In the case of patients who disclose or are known to have anger issues, mechanisms for recognition of triggers would be used. Past mental health diagnosis is well supported with stabilisation of the appropriate medications, consults and joining of both the key workers they have and psychiatrists with the team. In addition there is direct access to the psychiatric liaison service at Imperial Hospital and this runs on the unit every Friday for any patient who may need access to this either pre, during or post therapy.
- 3.45 At each clinic appointment, Peter was assessed. He was assessed and treated by a qualified nurse throughout his treatment course. The standard assessment process for patients on Peginterferon was conducted throughout Peter's care in accordance with best practice.
- 3.46 As the clinic were unaware of Peter's past schizophrenia, drug induced psychosis, history of drug overdoses, suicide attempts, or past incarceration for violence or previous incidents of domestic violence towards Rose (and towards both his and Rose's children) these assessments were not specifically targeting, or asking probing questions to elicit abnormal cognition or anger management concerns. Peter therefore was not seen by the psychiatric liaison service.
- 3.47 On review of the chronology of his clinic attendances, Peter is noted as being stable in mood. On the 26<sup>th</sup> of January 2012, Peter consented to participate in a biomarkers study. On 02/02/20102, it is stated that Peter reflected on the progress he had made since being abstinent from alcohol and illicit drugs. The notes also state that he was aware of the risks of his health should he drink alcohol.
- 3.48 Five days before Rose's death (08/03/2012), Peter was seen in the clinic and his mood is recorded as stable. It is noteworthy that at this visit he agreed to participate in a service user group to prepare them for anti-viral treatment at a local drug and alcohol clinic.
- 3.49 A slight deterioration in his health is noted on 16/02/2012 when he needed supervision to inject and "seemed unable to remember process alone". Later, on 23/02/2012, Peter reported feeling tired and that he was unable to attend the gym as usual. When he was seen a week later, his mood is reported as being stable.

- 3.50 Concerns were raised on 12/03/2012 about Peter (the day before Rose's death) following a telephone call from Rose stating that Peter's "mood had dipped and he spent most of the weekend in bed and was not very chatty". During the telephone conversation with Peter, he denied any thoughts of harm to himself or others. He reported feeling lack of energy and generally tired. It is noted that Peter was offered a swift response and an appointment was offered on the same day at 15:30 hours at St Mary's Hospital. A further telephone call was received from Rose cancelling the appointment later that day and the cancellation was confirmed by Peter. A previously booked clinic appointment was confirmed for 15/03/2012.
- 3.51 It is reported that Peter remained mentally stable and reported abstinence from illicit substances throughout his treatment.
- 3.52 It was not until 22/03/2012 that the clinic were advised that Peter was possibly in Police custody by Peter's GP surgery which was then confirmed the following day by a phone call from Peter's GP to the clinic.

### **Ealing Hospital NHS Trust<sup>10</sup>**

- 3.53 The hospital had contact with Peter, Rose and Peter's children. In 1993, Peter attended Accident and Emergency following an overdose, and he is recorded as a known registered IV drug user. It is noted that his girlfriend was not Rose. He is admitted for treatment in 1995 for an abscess on his right thigh, and noted as using heroin and injecting for years.
- 3.54 On 16/01/1998, Peter presented to Accident and Emergency. He was hearing voices, having hallucinations and requested to see a psychiatrist. Rose is recorded as his girlfriend and is noted as being very supportive. It is stated that he attempted suicide three years ago and had a nervous breakdown six years ago.
- 3.55 Following a road traffic accident in a letter requesting a neurology appointment dated 12/02/1998, it is noted that Peter was "attempting to wean off of hard drugs".
- 3.56 In July 1998, Peter presented to Accident and Emergency with headaches and vomiting. He is noted to be unkempt but not suicidal or having any psychotic concerns. There was no reference to drug use.
- 3.57 As part of Rose's treatment for a serious health condition, her records on 08/11/2005 give no mention of Peter, and is noted as divorced with two children, and on 16/11/2005 Rose gives one of her children's details as her next of kin. The mention that she was providing care to

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<sup>10</sup> It was confirmed at the end of the review, that Ealing Hospital Accident and Emergency department would be closed and replaced with an urgent care centre.

one of her adult sons did not trigger a carer's assessment. When she was prepared for discharge following surgery for her serious health condition on 16/11/2006, her support systems were not recorded.

- 3.58 From July 1998 to January 2006, Peter does not present to Accident and Emergency
- 3.59 On 19/01/2006, Peter attends with a head injury and it is noted that he is dependent on alcohol. He self-discharges.
- 3.60 On 21/07/2007, Rose attends Accident and Emergency following a fall with an injury to her right shoulder. She stated that she tripped whilst crossing the road. There is no evidence of domestic violence enquiry being conducted.
- 3.61 Peter attended Accident and Emergency on 26/01/2010 with a urinary tract infection and sores on his genitals. He makes a comment to the Triage Nurse that he "may have got it from his girlfriend". There is no evidence of a discussion about his relationship or consideration of any risk issues concerning Rose.
- 3.62 Rose attended Accident and Emergency following another fall on 28/07/2010. Peter is not mentioned and there is no link made to her similar presentation on 21/07/2007.
- 3.63 Emma (Peter's daughter) attended Accident and Emergency in December 2010 on two occasions following alleged assault from her partner. Neither attendance noted any advice being given to her regarding domestic violence, despite her direct disclosure of assault.
- 3.64 Community Health Services had little contact with both Rose and Peter.

### **Ealing Council Noise and Nuisance Team**

- 3.65 Noise nuisance reports concerning Peter's address were made between 2004 and 2009. The team had direct face-to-face contact with Peter in 2005 following several noise nuisance complaints made by a neighbour. The noise nuisance complaints were mostly concerning loud music. Peter appeared to be co-operative and compliant and the records do not indicate an aggressive response to the officer's contact with him.
- 3.66 Noise nuisance complaints were made by an anonymous complainant on 21/06/2004 and 15/02/2005. An email sent to the noise nuisance team on 07/10/2004 which described Peter as a "menace" and that he was throwing beer cans out of his window. A complaint of a flood was also made.

- 3.67 On 19/11/2004, a diary sheet was received and a warning letter was subsequently sent to Peter. A visit was made to Peter's address on 21/09/2005 (presumably following a complaint) and loud music was heard, but it is recorded that it was audible at a level that would not constitute a nuisance. The officer saw Peter who was described as being very intoxicated and "looked unwell". He was given a warning about the noise for which he apologised. In communication between the noise officer and the housing officer (at Ealing Homes) it was stated that "Peter was really drunk and could hardly stand up or talk. He looked terrible".
- 3.68 There was no evidence whether Peter was interviewed in 2005. Despite the documented concerns about Peter's appearance or behaviour, there was no follow up of these by either the noise team or the housing officer in respect of consideration of a safeguarding adults referral being made or consideration that any children may reside at the address that require safeguarding.
- 3.69 A further noise nuisance related visit to Peter's address were made on 14/10/2005 where he was asked to lower the volume of his music, to which Peter was compliant with and it was noted that Peter appeared intoxicated. This was the second time Peter had presented as being intoxicated. This report was again shared between the noise officer and the housing ASB officer (at Ealing Homes).
- 3.70 Noise nuisance reports were made in January 2006, and again more frequently between May and October 2007. Warning letters were sent to Peter for playing loud amplified music and he was issued with a noise abatement notice in June 2007.
- 3.71 Peter's daughter, Tina, made contact with the team (in July 2007) after he received the warning letter, disputing that her father was playing loud music. Following this contact with his daughter it is not recorded what enquires were made to determine whether there were any child protection concerns; although, there is no suggestion that the daughter appeared to be a minor and the documented conversation appears to be that of a mature reasonable adult.
- 3.72 It is noted that the visits made in October 2007 stated that the music or audible level of the television was not at a level to be considered a nuisance.
- 3.73 The team had no contact with Rose.

### **London Ambulance Service**

- 3.74 On 13/03/2012, a 999 call was received by the Emergency Operations Centre (EOC) at



00:02hrs to attend Peter's address. Initially the caller is a man; he starts to give the first part of the address but the call is then taken over by a woman. She completed the address, and telephone numbers (including verification) then explains the patient (who she refers to as Peter) has collapsed – that she had woken and found him on the floor.

- 3.75 Rose provided the medical history; that Peter is on medication for Hepatitis C and that he has been acting strangely for a couple of nights. The Emergency Medical Dispatcher (EMD) requested clarification and Rose relays that he “just felt really funny and ill”. Rose also said that Peter had spoken to the hospital who had explained his Hepatitis C medication was very strong and “that they should be careful” and let them know if anything happens.
- 3.76 The EMD triaged the call confirming that the patient is fifty-two years old, conscious and breathing. THE EMD asks if Peter is breathing normally; Rose is unsure and the EMD suggests Rose asks the patient. The EMD hears Rose do so and confirms that Peter is breathing normally but Peters reply is inaudible on the recording of the call. The EMD asks if Peter is completely alert and Rose replies: “no, not really”. Rose is then asked if Peter is changing colour; as Rose replies “no” Peter's voice can be heard in the background and Rose says “what do you mean you're feeling alright now”. Rose then goes on “Oh goodness, I didn't even know he'd called you”.
- 3.77 The EMD then asks the last of the key questions and then goes on to say “do you want us to still come down and check him over”? Rose then says that Peter has now recovered his colour. The EMD continues to offer for LAS to come to check Peter over and the caller asks him if that is what he wants. On review of the call, the first time there is possibly a negative response given in the background and subsequently, Peter can clearly be heard saying that he “just got confused on his medication”. The decision is made to cancel and the EMD reiterates that they should call back if Peter deteriorates or changes his mind.
- 3.78 Rose does not appear to initiate the cancellation; she reacts to the patient speaking; although, at this point Peter's response cannot be clearly heard. Subsequently in the call, Peter can be heard on the line indicating he does not want an ambulance and that he had been confused at the time he called. There is nothing to suggest any particular problems at the scene, Peter is clearly alert (responding appropriately) and Rose says, at the end of the call, that although he had been pale he had since recovered his colour.
- 3.79 The EMD acted within protocol and training on this occasion managing the call. There was no requirement within LAS protocols to speak directly to the patient. This was “cancelled as called”. The LAS confirmed that this is not unusual as people regularly make an emergency call, and then as the call proceeds, the patient recovers and the need for an emergency

response recedes.

- 3.80 The LAS have advised the review that approximately a third of calls could potentially be cancelled each day due to pressure levels, and some of these calls may be referred to other services such as the Police or their GP. Unlike the fire brigade (who will still attend even when a call is cancelled) the LAS take no further action when a call is cancelled. The only exceptions where call backs would be made to check that the caller is OK are when people can be heard distressed or other medical issues (such as chest pains) are disclosed. The nature of this call would not have triggered a call back.
- 3.81 Later on at 01:35hrs, a 999 call was received from the Metropolitan Police Service by the EOC to attend Peter's address. An allegation of a domestic stabbing was reported, it was further reported that the suspect was believed to be still at the location.
- 3.82 A Fast Response Unit, two ambulances, a Hazardous Area Response Team vehicle and a senior officer were dispatched between 01:37hrs and 01:54hrs, arriving between 01:47hrs and 02:08hrs.
- 3.83 On LAS arrival at the property, Rose was in cardiac arrest (as a result of the attack). The rest of the LAS IMR concerns the treatment of Rose at the scene.
- 3.84 It has been confirmed that the management of the 999 call and the care provided by the attending ambulance staff were in accordance with expected practice.

## **Ealing Homes**

- 3.85 There was no involvement with the Tenancy Management Team with either Rose or Peter prior to the murder of Rose. The Rent Team in Landlord Services had contact with Peter and Rose regarding their separate rent arrears accounts. Their rent arrears were accrued towards the end of their tenancies and were of relatively small amounts and as such did not warrant concern of further investigation. No eviction proceedings were instigated.
- 3.86 Following the incident of criminal damage to Rose's property on 04/01/1998, which required repairs, it has been confirmed as part of this review by housing repair service that it would have been very unlikely that Rose would have been asked about the cause of the damage and for domestic violence to have been asked about and considered.

## **London Probation Trust**

- 3.87 Peter was sentenced at Isleworth Crown Court on 08/12/1995 to a two year Probation Order of Affray. No further details of Peter's probation order are available due to the legal requirement to dispose of information six years from sentence end date.

## **Victim Support**

- 3.88 Both Rose and Peter were not known to Victim Support for matters related to domestic violence. Rose was referred for a burglary and robbery. The three reported non-crime domestics were not referred to Victim Support.
- 3.89 Both Rose's and Peter's adult children have all had contact with Victim Support for issues unconnected with this review.

# **Contact with family, friends and other people who knew Rose and/or Peter**

## **Contact with family members of Rose and Peter**

- 4.1 The guidance for conducting DHRs is very clear that families and friends should be a part of the DHR process. Engagement with friends and family members is important so that the review can be accurately informed about the nature of the relationship, attempts that may have been made to seek help and any contact with services. Family and friends are also invited to share their thoughts on what happened and what can be changed to prevent future deaths.
- 4.2 As part of this review, the chair has had brief contact with one of Rose's sons. The chair has spoken in detail with one of Peter's children and the content of those discussions is summarised below.
- 4.3 The information contained in this section and the beliefs of Peter's daughter will be further considered within the analysis section of this report.
- 4.4 The panel were unable to engage with any friends of Rose or Peter.

## **Peter's family's account of the relationship**

- 4.5 The following is a description of the relationship between Rose and Peter based on the conversations the chair has had with one of Peter's daughter's (Tina).

- 4.6 Tina viewed the incident that led to Rose's death as an isolated incident and as a result of her father's mental health issues. She repeatedly expressed her utmost disbelief at what her father did and stated that if only he had gone in the ambulance, Rose's death would not have happened.
- 4.7 Tina spoke of a loving relationship she had with Rose. She said despite Rose being her stepmother, she enjoyed a good relationship with her. It was apparent in discussions with Tina that her loss was significant as she had lost both her mother figure but also in effect her father. Tina commented that she felt it was disappointing that because she was Peter's daughter she was not offered the support of a Police Family Liaison Officer.
- 4.8 Tina described a "stormy relationship" between her father and Rose, which she thought was due to the use of drugs. Despite having their difficulties she said that Rose stood by and supported Peter. She said that she felt her father did love Rose and that they relied on each other. She described a life of domesticity between them.
- 4.9 There was a discussion as to whether Tina was aware of any domestic violence between Rose and her father or if Rose had ever spoken to her about problems in the relationship. Tina disclosed that her sister had previously asked Rose if her father had ever hit her (following their history of him assaulting them when they were younger) and Rose said no. The circumstances that warranted this discussion is not known. This is the only conversation Tina recalls with Rose about the possibility of domestic violence in their relationship.
- 4.10 Tina described previous times when Peter's mental health had caused her and Rose concern. She described several incidents where her father acted strangely - "talking gibberish about the CIA," being paranoid, manically laughing for no reason and an episode in Devon at a funeral with Rose when she was a teenager. On that occasion Rose took Tina and her sister home to London. She said that Rose would often leave Peter to his own devices when he was being "odd".
- 4.11 After Peter was sectioned in Devon (in 1998), Tina said that her father stopped using illicit drugs; although, he would drink alcohol (typically once a month he would go on a binge when he received his Disability Living Allowance). Following his return from Devon, Rose and Peter lived together for some time, but they eventually decided to live apart.
- 4.12 In the week prior to Rose's death, Tina said that she noticed that Peter did not want the TV on and he would just sit in his room staring out into space. He would talk to himself and laugh at something out of the blue.

- 4.13 Tina was asked if she could think of any times or opportunities when different intervention may have helped her father and prevented Rose's death. Tina was concerned about the possible delay with the Police and LAS being deployed and arriving at Peter's address. This has been explored by the panel and no undue delay was identified. Tina repeated that she felt that had her father gone to hospital that night, Rose would still be alive.
- 4.14 Tina also raised her concerns about what support her father had in the community when he returned from Devon after being detained under the Mental Health Act.
- 4.15 Following the meeting with Tina to share the draft overview, Tina contacted the chair and requested that the report included a more accurate description of her father's accommodation. This is in relation to the various complaints made by Peter's neighbours concerning his behaviour, specifically throwing beer cans out of his window.
- 4.16 Tina acknowledges that her father at this time was binge drinking. She highlighted the nature of the housing, and asked if it was confirmed that it was her father who was throwing the beer cans out of the window. Tina described the block of flats as being densely populated and in poor condition, and that there were many problems with how other residents behaved. She stressed that she could not imagine her father behaving in that way.

# Analysis

- 5.1 There was a history of reported domestic violence between Rose and Peter albeit this was limited to three non-crime domestics over a twelve year period:
- 5.1.1 04/01/1998 – Criminal Damage to Rose’s property
  - 5.1.2 16/06/2003 – Peter was drunk and would not leave Rose’s property
  - 5.1.3 11/02/2010 – Neighbour reported hearing a woman screaming.
- 5.2 There is a documented history of domestic violence involving Peter. There are Police records of domestic violence between Peter and an ex-partner in 1993 (assault with a table leg), and also in 1999 (threats to assault). In 1998 Peter’s girlfriend (thought to be Rose) disclosed an incident of domestic violence to mental health professionals. There were also reports of violence between Peter and Rose’s sons and also with his daughters.
- 5.3 The three incidents reported to the Police between Rose and Peter were all non-crime domestic incidents, and therefore they would not have met the threshold for referral to the Ealing Multi Agency Risk Assessment Conference (MARAC). Although the MARAC implemented in the borough 2010 (and after the last Police report) the non-crime domestic could have been referred to Victim Support and Peter could have been risk assessed as they were already using the CAADA DASH RIC<sup>11</sup> at this time. This process would have supported discussions with Rose about her relationship with Peter and concerns she may have had.
- 5.4 The non-crime domestic incident in 2010 (when a neighbour reported that they heard a woman screaming) was not progressed appropriately by the Police. As the Police officers were unable to locate and speak with Rose that evening, they opened a CAD for this to be followed up later. This was an appropriate course of action; however the Police officers who then went to deal with this only spoke with Rose’s lodger and not with Rose personally. This contact with her lodger was then followed up again several days later, and again Rose was not spoken to or seen face to face by the officers. They took the account of a neighbour that Rose had been seen and there was no concern for her welfare.

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<sup>11</sup> The CAADA DASH Risk Indicator Checklist (RIC) helps practitioners identify high risk cases of domestic abuse, stalking and ‘honour’-based violence and decide if the case needs to be referred to a MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management. The tool enables agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and ‘near misses’, which underpins most recognised models of risk assessment.

- 5.5 The Police should not have closed the call until Rose had been directly spoken to about the incident.
- 5.6 The review has established that not every non-crime domestic incident is automatically referred to Victim Support. The individual Police officer who attends the scene, assesses and uses their professional discretion to decide whether to refer a non-crime domestic to Victim Support (when the victim's consent has been obtained). Due to funding issues, only domestic violence crimes are automatically referred to Victim Support as part of the daily automatic data transfer (once the victim's consent has been obtained).
- 5.7 For non-crime domestic incidents, the Police officer would make an assessment as to whether a referral would be helpful given information gathered from intelligence checks (such as the history of any previous reports) and the nature of the incident. The issue concerning referral practices from non-crime domestics and the lack of funding for these incidents to be referred to Victim Support is a national issue and not just specific to the London borough of Ealing.
- 5.8 Despite the IDVA (Independent Domestic Violence Advocate) being co-located in the Police Community Safety Unit (CSU) and a local agreement in place for individual officers to make referrals to the IDVA, this process and arrangement is not formalised in writing.
- 5.9 Locally there is a lack of clarity of the referral process to domestic violence services. Work has been progressing to agree a borough pathway of how domestic violence cases are referred, what services work with what victims and what each service does. The borough has a diverse range of specialist domestic violence service providers and so clarity of what each do is needed so that professionals are informed and are better placed to support and advise victims.
- 5.10 Discussion at the panel revealed that the diverse range of specialist domestic violence services in the borough work together and they all have a good detailed understanding of what each other offer so that victims are able to access the right service for their needs and circumstances. The borough needs to recognise the diversity of domestic violence services available, whilst ensuring referral processes and publicity information are clearer and easy to navigate (for professionals, victims and the wider community). Referral processes are currently informal and seem to rely on ad hoc professional relationships and previous contact/experience with a particular domestic violence service or worker. This can lead to victims falling through gaps or experience the trauma of having to duplicate and recount their experiences in their journey to accessing the right service for them.

- 5.11 The panel had mixed views on the solution to this issue. A model reflecting a Multi-Agency Safeguarding Hub (MASH) where domestic violence services would be located together to triage referrals and ensure that they are swiftly referred to the correct service, a single point of contact or a one stop model were all explored. There was agreement that referral processes need to be set out in writing and shared across the partnership and publicised to the community to encourage individuals to be able to access support.
- 5.12 It is positive that the IDVA has been co-located within the Police CSU two to three days a week (since 2012) and that these cases are all subject to assessment using the CAADA DASH RIC. The panel agrees that a domestic violence referral pathway will help to improve practice and encourage consistency in the response to victims (particularly for those who have contacted the Police).
- 5.13 It is encouraging that during the period of this reconvened review, work has progressed locally (lead by Southall Black Sisters) to agree and produce a borough domestic violence referral pathway. This has been shared with the panel and it is clear, simple and easy to navigate. It is hoped that this will help to clarify to professionals and practitioners the various different specialist domestic violence services operating in the borough as the referral criteria is included as is an outline of what each service provides. This needs to be widely circulated across the borough. The pathway needs to be underpinned and supported by a fully functioning and an effective coordinated community response to domestic violence to ensure that victims do not fall through gaps and that they can easily access information and support.
- 5.14 There are several incidents in the chronology where domestic violence enquiry would have been opportune, relevant and possibly beneficial:
- 5.14.1 29/12/2008 – Rose attends Ealing Hospital for injury to right side rib
- 5.14.2 From November 2008 when Rose was being treated for a serious health condition (in relation to what support she had at home). She was seen by her GP and the hospital regularly about this and it is surprising she was not asked about her relationships or her home life given the nature of her health concerns and that she may have needed emotional and practical support.
- 5.14.3 21/07/2009 – Rose attends Accident and Emergency following a fall. She was seen also by the GP about this. On both consultations the cause of the injury was accepted; however, later on 28/07/2010 she presented at Accident and Emergency again reporting another fall. The cause of the injury and the fact this was similar to her attendance in 2009 was not questioned.



- 5.14.4 04/08/2010 – Rose seen by GP regarding the second fall.
- 5.14.5 07/12/2012 – Rose has a routine smear test.
- 5.15 There are also several incidents in the chronology where consideration of domestic violence and exploration of domestic violence risk assessment with Peter should have been made:
- 5.15.1 26/03/2008 – Peter given standard generic information on sexually transmitted infections
- 5.15.2 26/01/2000 – Peter seen at Ealing Hospital for a sexually transmitted infection and stated in triage that he “may have got it from his girlfriend”
- 5.15.3 03/09/2010 – Peter diagnosed as Hepatitis C positive. GP provided generic safe sex advice (to use condoms to protect his partner).
- 5.16 In both of the GP IMRs it is noted that their records showed no signs of domestic violence. There was no evidence of the indicators of domestic violence, any direct self-disclosure of domestic violence from Rose or that the prospect of domestic violence was ever considered. It is noted that Rose was known personally at her GP practice. The panel discussed whether this may have influenced the nature of enquiry for domestic violence by clinical staff.
- 5.17 As part of the GP IMR process, both Rose’s and Peter’s attendances at hospital and other critical dates were cross referenced with their GP records and no issues concerning the risk of domestic violence were identified.
- 5.18 The GP practices concerned in this review have confirmed that they do not have a domestic violence policy or had ever received specific training on domestic violence awareness nor conducting clinical screening and enquiry for domestic violence. The lack of a domestic violence policy for GPs and ensuring staff receive specific domestic violence training for GP practice staff is recognised as a borough wide issue and not specifically isolated to the two GP practices concerned in this review.
- 5.19 It is concerning to have learned as part of this review, that one of the GP surgery’s (due to its close proximity to the borough’s domestic violence refuge) was previously offered domestic violence training but that take up was limited and engagement by the DV service with the practice has been difficult. The review has made efforts through the panel representatives for NHS England and Ealing CCGC to expedite the provision of domestic violence training and publicity materials to the two GP practices concerned.

- 5.20 One of the GP practices concerned stated that domestic violence training is now planned. This is a welcomed development; however, a borough wide GP domestic violence training initiative is needed in order to help support improvements across the board.
- 5.21 The borough should therefore consider commissioning the IRIS Project<sup>12</sup> to improve primary care's response to domestic violence. It is also hoped that the NICE Guidance (PH50) Domestic Violence and Abuse – how services can respond effectively<sup>13</sup> will help to improve the health service's response to domestic violence (particularly from general practice).
- 5.22 Peter's daughter said that her father and Rose had decided to live apart, which could be an indicator that life together was difficult or stressful. There is no evidence of any support provided to Peter for his historical mental health issues or to Rose for her serious health concerns. When Rose was discharged from hospital following surgery for her serious health condition (on 16/11/2006), her caring role was not explored nor was Peter's own support requirements documented. This would appear to be a gap in the care planning for Rose given the seriousness of her condition. There is no record of any domestic violence enquiry being conducted or their relationships being explored.
- 5.23 In 1998 during Peter's admission in Torbay Hospital, it is stated that Peter's girlfriend (now thought to have been Rose) disclosed concerning behaviour by him towards her on one occasion when he was unwell and under the influence of drugs (this incident was Peter driving on the wrong side of the road at high-speed to test if she was being unfaithful, holding a knife to her throat).
- 5.24 Due to the date of this disclosure and the length of time of Rose's and Peter relationship, this information was rechecked to confirm whether the girlfriend mentioned was actually Rose. Peter's daughter thought it could have been Rose; however, the WLMHT records (a report dated 27/03/1998) states that Peter's partner leading up to and including 1998 was a woman called Karen. It is stated that he had a previous partner called Paula. It is unclear in the report when the relationship with Paula ended and the relationship with Karen started.
- 5.25 Rose had ongoing frequent contact with her GP due to treatment and care for her serious health condition, compared with Peter who was visiting his GP less frequently and his contact was considered as being more episodic. During Peter's contact with clinicians, it seems that Rose is invisible. This may have been reinforced by the fact that they were

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<sup>12</sup> IRIS Project is a general practice-based domestic violence and abuse (DVA) training support and referral programme. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing domestic violence and abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators <http://www.irisdomesticviolence.org.uk/iris/>

<sup>13</sup> <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=14384>

registered at different practices and the limits of sharing information due to patient confidentiality. Despite a partner being referred to in Peter's consultations, there is no evidence of consideration of the risks presented to her and what safeguarding actions may need to be considered.

- 5.26 It is recognised that it would have been particularly difficult due to the context of the consultation for the Triage nurse to have directly addressed risks to Peter's girlfriend on 26/01/2000, but his statement could have been explored further.
- 5.27 There was no evidence of a carer's assessment being requested or conducted in regard to Rose providing care to Peter (as described by Peter's daughter or when Rose said she was providing care for one of her sons).
- 5.28 It is concerning that despite it being a condition of Peter's Probation Order, his engagement with community drug and alcohol services in 1995 was intermittent. Due to the destruction of his probation records we do not know how his lack of engagement was handled by probation.
- 5.29 Despite his lack of engagement, it would not have been appropriate to have discharged him from the service, as he was subject to a court order. It should be noted that the nature of offender supervision and probation case management has changed significantly since that date.
- 5.30 The complaint sent to the Noise Nuisance Team concerning Peter (October 2004) appeared to indicate that there may have been wider problems beyond that of simply noise nuisance. The flooding issue in Peter's flat would not, in normal circumstances, be sufficient to warrant a safeguarding concern. The complainant's references to throwing empty beer cans out of a window and reference to Peter as 'a menace' may have indicated wider anti-social behaviour issues. No follow up about these other matters was recorded and direct contact and questioning of the complainant may have yielded wider concerns.
- 5.31 It was noteworthy that the noise nuisance officer who attended Peter's address on 21/09/2005 (following a noise nuisance complaint from a neighbour) in their notes stated (Peter) "looked unwell" and that "he looked terrible". This contact with Peter would not necessarily raise significant safeguarding concerns but may have been an indication of safeguarding vulnerable adult issues. This should have warranted a consideration of vulnerable adult and liaison with the Safeguarding Adults Team.
- 5.32 At the second direct contact the Noise Nuisance Team had with Peter on 14/10/2005, Peter again appeared intoxicated but it is recorded that he was compliant. The Noise Nuisance

Team informed the panel that it is not unusual for them to find that the subject of a noise complaint is intoxicated, as complaints of loud music are often associated with parties and celebrations when alcohol is consumed, especially late at night.

- 5.33 It is recognised that despite Peter being described by one of his neighbours to the noise nuisance team as a “menace” in their contact with the team on 07/01/2004. It is unlikely that his presentation to the noise nuisance officer that he “looked terrible” and his noted alcohol use would have met the threshold for statutory safeguarding adults intervention concerning the possibility of him posing a risk of harm to himself and others.
- 5.34 Peter’s daughter Tina contacted the Noise Nuisance Team on 23/07/2007 following receipt of the warning letter concerning amplified music. The notes of this conversation raised no direct concern.
- 5.35 The Noise and Nuisance Officers and Response Officers have now received training to identify indicators of domestic violence, child safeguarding concerns and wider vulnerabilities when dealing with their routine contacts with members of the public.
- 5.36 When a noise nuisance complaint is received the procedure now is that questions are asked of the complainant to help identify any vulnerabilities. The Council’s Noise and Nuisance Officers and Community Safety Officers (whose responsibilities include dealing with tenancy enforcement with regard to anti-social behaviour) now work together in clusters, which promote information sharing between the Noise Nuisance and Community Safety Team. Officers can directly liaise with the Risk Coordinator in the safer communities team, who coordinates the response to high risk cases of vulnerability and repeat victimisation ensuring that the response to high risk cases is in line with national/local policy and legislation in relation to Safeguarding vulnerable adults and children.
- 5.37 The Housing Repairs Service now follow different systems when responding to a repair request. The tenant is asked about the nature of the repair and how the damage was caused. Appropriate referrals for support are then made. The tenant is asked to supply a crime number from the Police, and if the incident had not been reported to the Police they are asked to do this. The council’s Community Safety Team and Housing Officers would also be advised of the incident. Contractors who do the repairs have received safeguarding adults training and understand that they must report back any concerns if they identify any safeguarding concerns. It was confirmed that such safeguarding reports from repair contractors are rare.

- 5.38 It is good practice that all reports to the housing repairs centre are now all screened regarding the possibility of domestic violence. However as it is noted that such reports are rare, this reflects that more work on this is needed with housing providers and repair contractors. They need to be included in the borough's coordinated community response to domestic violence so that domestic violence reports are increased and that tenants are appropriately supported.
- 5.39 The review has recognised the welcomed and positive developments undertaken by Ealing Hospital concerning its response to domestic violence. The Trust's Domestic Violence Policy (2012) is comprehensive and detailed. The policy provides guidance and advice for managers to support employees who are currently suffering or have suffered as a result of domestic violence. The policy also provides evidence based information for professionals to escalate concerns using risk assessment tools.
- 5.40 The policy sets out that professionals are expected to routinely screen for domestic violence (if suspected). Professionals are also expected to complete the CAADA DASH RIC and comply with the organisations existing policy on information sharing and best practice guidelines.
- 5.41 Ealing Hospital's named nurse for safeguarding children or named midwife attends the Ealing MARAC and shares proportionate and relevant information with appropriate colleagues.
- 5.42 Ealing Hospital has a domestic violence lead and a senior Accident and Emergency staff nurse who are well placed to offer support and advice to colleagues. The domestic violence lead is an active member of the Domestic Violence Task Group and is also a member of the Ealing Hospital Safeguarding Adults Group (a forum for dissemination of any new guidance and best practice developments).
- 5.43 Training around domestic violence awareness, MARAC processes and risk assessment tools is embedded within Ealing Hospital's Level 3 Child Protection training study days. It is a mandatory requirement for staff working frontline with children and families to attend Level 3 training. This would capture staff working in Accident and Emergency who would often work frontline when victims of domestic violence access services.
- 5.44 This training does not always reach staff working in other areas of Ealing Hospital, (such as those working on wards or in community based settings). When Rose was being treated by the hospital for a serious health issue it is not recorded whether she was asked about her relationships or the support she had. Given her serious health concerns it would seem

appropriate and necessary to establish what support she had around her. Whilst it is recognised that domestic violence enquiry at such appointments may be extraordinarily difficult, a discussion about her home life and support may have prompted an exploration of her relationships and eventually a sensitive domestic violence enquiry could have possibly been made.

- 5.45 All Ealing Hospital staff should receive training on domestic violence which is appropriate to their roles and responsibilities to promote and ensure an organisational response. To promote take up and engagement with the training, the organisation should consider this as a key performance indicator and mandatory requirement.
- 5.46 The response to domestic violence by Ealing Hospital can be further enhanced by the provision of IDVAs on site within Accident and Emergency to support clinical enquiry for domestic violence and timely crisis intervention as well as providing access to other domestic violence services available locally (depending on the patients needs).
- 5.47 The panel questioned the seemingly informal nature of Peter's discharge in 1998 from mental health services when his GP told Mental Health Services that Peter was seeing a doctor 'down the coast' which resulted in him being discharged from WLMHT.
- 5.48 WLMHT discharge practices have since changed. A "Notice to GP of intention to Discharge" is sent to the patient's GP. If the GP is in agreement with the plan to discharge, the GP must confirm this by returning a slip.
- 5.49 In addition to the discharge notice sent to GPs, WLMHT clinicians receive a training package on 'Safe Discharge Methodology' which includes the following:
- 5.49.1 GP/Secondary Care shared decision consultation period.
  - 5.49.2 Secondary Care Discharge meeting where discharge arrangements are finalised and service user is fully discharged according to shared discharge plan.
  - 5.49.3 In the event of relapse after discharge, the GP contacts the discharging team for advice or contacts the single point of referral for assessment as per details of the Discharge Template/Care Plan.
- 5.50 WLMHT have also given assurances that GPs are now routinely contacted when they have concerns about a patient and that patients are provided with out-of-hours contact details for further support. WLMHT would contact the individual directly by telephone as well as writing

to them if they had not attended an appointment. In addition the GP would be contacted and written to.

- 5.51 WLMHT engage with the MARAC and staff should use the risk assessment tool contained within RiO (WLMHT's NHS clinical records electronic system). In order to support practice and timely risk assessment, this should include access to the CAADA DASH RIC.
- 5.52 Since Peter's last contact with Mental Health Services, there have been a number of changes on how safeguarding concerns are dealt with and managed. All WLMHT staff participate in mandatory safeguarding training and there are named professionals that provide guidance to those staff who identify concerns relating to domestic violence and abuse.
- 5.53 It is good practice that WLMHT's induction and mandatory safeguarding training (both children and vulnerable adults) does reference domestic violence. The Trust is in the process of finalising the recruitment of two additional posts to join the corporate safeguarding team. These posts will help further improve the safeguarding response to vulnerable adults (including developing the response to domestic violence) through access to expertise and increased training capacity.
- 5.54 In comparison, GP responses to domestic violence are located within the vulnerable adults framework. It is important, that given the complexity of domestic violence, the issue is highlighted as a specific separate safeguarding agenda and is not lost by being incorporated within the safeguarding response to children or adults.
- 5.55 The review recognises that WLMHT is actively working to ensure domestic violence is visible in safeguarding responses to patients. Their newly updated safeguarding adults policy has been subject to expert review by the AVA Project to ensure it appropriately covers domestic violence. There are robust systems in place to audit workforce take up of safeguarding training and updates, which is done through a score being scrutinised on a monthly basis looking at each team's take up of compliance to ensure training compliance rates are achieved.
- 5.56 WLMHT's organisation intranet site includes comprehensive information on domestic violence as well as the relevant forms concerning the MARAC (including the CAADA DASH RIC). Efforts have been made to help ensure that the information is easily accessible for staff to support and inform their practice.
- 5.57 During the course of the reconvened review, WLMHT have been developing a dual diagnosis strategy, which is currently awaiting corporate sign off.

- 5.58 The Ealing MASH is still in its infancy and is children focused. Ealing Children's Social Care implemented the MASH model from July 2012. The MASH sits with the single point of contact called Ealing Children's Integrated Response Service (ECIRS). The MASH includes the following domestic violence provision:
- 5.58.1 A Domestic Violence RAP which addresses emotional support and resilience building to any child four to eighteen years old who has been exposed to domestic violence which includes older children who may be violence/abusive to siblings/parents/intimate partners
  - 5.58.2 DVIP, (a RESPECT accredited violence prevention programme). Offers assessment and treatment to men aged 18+ as part of a violence prevention programme.
  - 5.58.3 Specialist domestic abuse workers within Children's Services and SAFE (Ealing's early intervention service) who will undertake safety planning with children and people experiencing domestic violence.
- 5.59 Within the MASH the Police Merlin report is screened and an appropriate rating is applied. Cases can be referred to MARAC by staff working within ECIRS. If cases were already open and allocated to Children's Social Care then the Police Merlin report would be followed up by the allocated Social Worker which could lead to a Section 47 (child protection) investigation.
- 5.60 The MASH provides an integrated safeguarding response service; however, it is noted that currently the arrangement does not include representatives from Adult Social Care or Adult Mental Health Services. There is a named contact within WLMHT when information and checks are needed. Having these services in MASH, as well as ensuring that there is domestic violence expertise within the arrangement, would help to provide a more timely and coordinated response to cases which would not meet the threshold for statutory safeguarding intervention, such as in this case and the concerns identified respectively with Peter's deteriorating mental health.
- 5.61 Although Mental Health Services are not part of the Ealing MASH, there is a Mental Health and Drug and Alcohol link and provision of twenty-four hour psychiatric liaison across the trust. There are now two full-time drug and alcohol assessment workers located within Accident and Emergency, and as a result of a serious case review they now hold a safety net meeting once a week.



- 5.62 Given the known side effects of Peter's anti-viral medication (and Peter's own concerns about the side effects of his medication on his mental health), there should have been a formal liaison with his GP about his history to fully establish any mental health concerns.
- 5.63 Whilst recognising Peter received a good standard of care from the Hepatology Clinic (and the timely response offered to Peter on the day before Rose's death), the reliance on his self-disclosure of his mental health concerns influenced his treatment plan. There was a gap in what information was verified with the GP and also what was shared by the GP in the original referral concerning Peter's mental health history. This lack of information impacted on the safeguards put in place in an attempt to monitor any deterioration in his mental health as a result of possible Peginterferon-induced psychosis.
- 5.64 On the day before her death, Rose reported her concerns about Peter's mental state deteriorating to his nurse. This shows the rapport that Rose had developed with Peter's nurse but could also be an indicator that Rose may have not had any other source of support to approach for help.
- 5.65 It is noted that the response offered to Peter that day was swift with an appointment offered that same day; however, he later cancelled the appointment which was made for him at the hospital. As there were no known active present issues concerning Peter's mental health or any concerns about his alcohol or substance use, he did not have a key worker in the community and there was not a coordinated care package in place. His GP was not engaged in his care plan. This meant that there was not an opportunity or ability to arrange a multi-disciplinary approach to the concerns Rose had raised about Peter's behaviour and mood – which could have included a home visit being made to him that afternoon.
- 5.66 Had Peter's past history been known, the clinic would have taken a different approach to his treatment – such as a referral to the in-house liaison psychiatric team which could have led to a different response to the concerns raised on the day before Rose's death.
- 5.67 Finally, support systems for families affected by fatal domestic violence should be strengthened. Family structures, dynamics and relationships vary significantly and a uniform approach to the provision of support can mean that certain family members can be isolated from information and support. The potential issue of conflict of interest needs to be sensitively and carefully managed. This is particularly relevant for step or blended families when the biological parent is the perpetrator.

## Themes Identified In This Review

### 5.68 Peter's mental health

- 5.68.1 Peter had a documented history of experiencing periods of poor mental health in the 1990s and his last contact with WLMHT was in 1998. This history was not evident in his GP record, and appears not to have been a factor or consideration in his contact with them since registering with his GP in 2007.
- 5.68.2 It would appear that Peter's history of mental health concerns was not sufficiently captured in the transfer between GPs. This resulted in the detail of his history being lost (no mental health diagnosis marker added to his record), and this impacting on the health care and support he subsequently received, notably from the Hepatology Clinic. The clinic conducts a detailed mental health assessment and if Peter's mental health history had been known there may have been a discussion as to whether anti-viral treatment was in fact possible as no other alternative drug is available.
- 5.68.3 The review has been informed that Ealing CCG, (in association with the other CCGs within the CWHHE Collaborative), is arranging for its member GP practices to move to SystemOne electronic records. It has been confirmed that safeguarding issues will be addressed across the CWHHE CCG during 2014 to ensure that appropriate coding is used within the system to allow identification of safeguarding concerns on patient records.
- 5.68.3 Peter's Personality Disorder may have impacted on his relationships with both Rose and the children. Given the complexities of Personality Disorders it is likely that his mental health would have at points, had a negative impact on family relationships and that Rose may have had to modify her behavior to "manage" him.

### 5.69 Information sharing between health services

- 5.69.1 Peter's treatment by the Hepatology Clinic was not informed by his full medical history due to the lack of a diagnosis marker being included in his GP records concerning his previous mental health concerns. It seemed that this information was not included in the transfer summary when Peter changed his GP so this historical information was lost over time.
- 5.69.2 The Hepatology Clinic is informed by GP information but also heavily relies on patient disclosure as part building rapport and developing the clinical relationship. The referral to the Hepatology Clinic from Peter's GP did not include information about his previous mental health concerns and contact with Mental Health Services. This gap

in information about Peter is significant, given the likely side effects of his anti-viral medication may have had on his mental health.

5.69.3 The Hepatology Clinic does not have a formalised system in place to independently verify information from patients, which means there is an over reliance on patient full and accurate disclosure and may have a negative impact on their care and treatment.

5.69.4 The Hepatology Clinic assesses approximately between five hundred to six hundred patients a year. Given the volume of patients they see, assessment is very much informed by GP information and patient disclosure, which they need to take at face value which is supplemented by their own clinical assessment. The clinical relationship is informed by a detailed assessment process due to the long lead in time into treatment and that the sharing of information from patients is a fine balancing exercise. Whilst it is acknowledged that this is important for building trust, rapport and not further stigmatising patients, the process of gathering information as part of assessment process needs to be more accurately informed and verified by other sources of information.

5.69.5 The information exchange between Peter's GP and WLMHT in 1998 was brief and his discharge to his GP at the time appears to have been informal. On his transfer to his current GP (the GP involved in the review) there was no mention of his previous contact with Mental Health Services. This information became historical, as demonstrated by its lack of reference in the IMR submitted to the review by Peter's GP. His history was not reviewed and did not inform the care from his GP or from the Hepatology Clinic.

5.69.6 Issues with timely information sharing between health services is particularly highlighted with the delay of notification to the Hepatology Clinic of Rose's death by the GP.

5.69.7 The review welcomes the move by Ealing CCG, in association with the other CCGs within the CWHHE Collaborative, to SystemOne electronic records. The CCGs are encouraging local NHS providers to use the system or a compatible system, which it is hoped will help improve effective information sharing with patient consent.

## 5.70 **Family functioning**

5.70.1 There were reports of domestic incidents between Rose and Peter as well as between Peter and Rose's children and also between him and his own children and ex-partners. There were also other reports of inter-family violence and also reports of

domestic violence in some of the children's own intimate relationships. It seems as though that when the families lived together there was conflict between Peter and Rose's sons, and that this was a stressful domestic living arrangement.

#### 5.71 **Carer responsibilities and barriers of being able to seek help**

5.71.1 It is stated that Rose was providing care for one of her sons and that she was also a carer to Peter. There is no record of a carer's assessment for Rose, and so it is not expected that she received any formal support for this (in respect to Peter or her son).

5.71.2 Rose and Peter had been together in a long term relationship before they agreed to live separately. Rose referred to Peter as being her ex-partner in her contact with the hospital in 2010. Rose may have experienced a conflicting struggle about wanting and needing to care for Peter and not wanting to be in a relationship with him. This may have prevented her from being able to seek help regarding his behaviour.

#### 5.72 **Risk Assessment**

5.72.1 There was no evidence of any specific risk assessment being conducted. When domestic violence was directly disclosed to WLMHT in 1998, this did not trigger a risk assessment about the issues identified.

5.72.2 There was no consideration of the risks Peter posed to Rose in relation to his mental health or his comments made to the hospital that he thought his partner had infected him with a sexually transmitted infection.

#### 5.73 **Understanding and awareness of the dynamics of domestic violence and its impact**

5.73.1 The services which had contact with both Rose and Peter showed no awareness of domestic violence, or an acknowledgement of it being a prospect in their lives. Even when partners were mentioned, this did not trigger enquiries to be made about their relationships. There was a lack of appropriate curiosity about their family lives and support networks.

5.73.2 The comment included in the WLMHT records; that there was disclosure of domestic violence on one occasion but in interview (it is now assumed to be Rose) stated that there were not "*any other incidents of regular domestic violence*" highlights a lack of understanding and awareness of the dynamics of domestic violence. This comment raises the question of what was meant by the phrase "regular domestic violence" and that a disclosure of violence had been made and that was not taken seriously.

5.73.3 The lack of recognition and awareness of domestic violence is a result of staff not being trained. Staff need to know about indicators and domestic violence risk factors. Services need to prioritise the issue of domestic violence and ensure staff are supported through policy and procedures and are trained so that they understand the behaviour and know how to respond to concerns.

#### 5.74 **Police action**

5.74.1 There was little Police involvement between Rose and Peter. The three incidents were all classed as non-crime domestics which were not referred to Victim Support. Rose should have definitely been seen and spoken to by the Police following the incident in 2010 to establish how she was and if she had any concerns as this would have been an opportunity to offer her specialist domestic violence support.

#### 5.75 **Culture of questioning**

5.75.1 The WLMHT gave reference to enquiry about domestic violence being made back in 1998; however there is no information about how this was conducted and what questions were asked. This is the only mention of enquiry in all service contact with Rose.

5.75.2 There was no enquiry about their relationships or support networks. This seems a significant omission given Rose's serious health concerns and Peter's presentation.

## **Conclusions**

### **Preventability**

- 6.1 The panel have carefully considered the events that unfolded in Peter's flat leading to Rose's death and him stabbing her in the presence of the Police officers.
- 6.2 There is a view held by Peter and also Tina (which was also expressed by the Judge at Peter's sentencing hearing), that if the call for the ambulance (before Peter assaulted and stabbed Rose) had not been cancelled, Rose may well have survived. This may have been the case if the ambulance reached Peter before he commenced the attack on Rose.
- 6.3 It has been confirmed that the Police officers who attended the scene were wearing standard issue kit (equipped with a stab vest, CS spray and asps). The CS spray used twice on Peter was ineffective. It was thought by Police representatives at the panel that had a Taser been available, the attending officers would have been able to demobilise Peter and this could have prevented him from stabbing Rose again. At the time of the incident, uniformed

response Police officers within the Metropolitan Police Service were not deployed with Taser. This has since changed.

- 6.4 As part of this review, the Metropolitan Police Service have confirmed that the use of Taser by Specialist Trained Unit Officers (STU's) only commenced across MPS boroughs in April 2013. Each borough now has a compliment of forty STU officers. This provides for each borough team to have four STU officers on duty per shift, ideally working in pairs. The rationale for this arrangement is to ensure there is support should the Taser deployed by one officer be ineffective.
- 6.5 In deciding the preventability of Rose's death, the panel are not able to absolutely state that had the call to the LAS not been cancelled whether it would have arrived in time to prevent (or even intervene earlier) in Peter from attacking Rose and possibly avoiding her death.
- 6.6 Upon the arrival at the scene by the Police and the LAS, Rose had already sustained serious injuries. We do not know whether her life would have been saved regardless of their intervention and medical care given at the scene.
- 6.7 Finally, the panel were of the view that given the injuries Rose had already sustained by the time the LAS and the Police arrived, it is unlikely that the final blow inflicted on Rose in the presence of the Police was in fact fatal<sup>14</sup>.
- 6.8 The panel noted the Judge's comments that the response of the officers at the scene was noteworthy of praise.
- 6.9 The anti-viral medication Peter was prescribed is documented to induce a number of psychiatric disorders. Peter was subject to the standard assessment for patients on Peginterferon. His treatment for Hepatitis C was only informed by his own self-disclosure of his mental health. His mental health history was not verified with his GP, nor was his mental health history included in the referral made by the GP to the Hepatology Clinic. The lack of information about Peter's previous mental health, his assessment and the safeguards put in place to manage the side effects of his anti-viral medication, were factors that contributed to the deterioration of his mental health in the days before Rose's death.
- 6.10 The report has shown the various missed opportunities to engage with Rose and enquire about her relationship, support networks and also the prospect of domestic violence in her relationship with Peter.

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<sup>14</sup> This was not view was a general consensus of the panel and was not of specific expert medical opinion.

- 6.11 Due to the uncertainty of the impact and relevance of all of the above factors, the panel have been unable to definitely confirm the exact chain of causation leading to Rose's death.
- 6.12 The panel are therefore of the view that there was not a single identifiable point of contact with a service or a significant incident that could have been a defining moment where different intervention could have prevented Rose's death.

## **Diversity**

- 6.13 The protected characteristics as outlined in the Equality Act 2010 have been considered in relation to this case:
- 6.13.1 **Age:** At the time of her death Rose was 58 years old and Peter was 52 (no relevant issues identified).
- 6.13.2 **Disability:**
- a) There is reference to Rose's caring responsibilities towards Peter and her youngest son. There is no record of a caring assessment being conducted.
  - b) Peter's historical mental health issues as well as having Hepatitis C could be considered as a vulnerability and being somewhat disabling. Hepatitis C is a chronic condition which is often stigmatised which may have made accessing help difficult.
  - c) It would appear that Rose received little support in her care towards Peter. There may have been feelings of responsibility towards Peter which may have made it difficult for Rose to seek help. It is likely that Peter's mental health concerns and his Hepatitis C would have an impact on his (and Rose's) daily life. This is supported by comments made by Peter's daughter that Rose would return to her own flat when she needed a break from Peter's behaviour.
- 6.13.3 **Gender reassignment:** Not applicable.
- 6.13.4 **Marriage and civil partnership:** The couple were not married but had been in a long term relationship (no relevant issues identified).
- 6.13.5 **Pregnancy and maternity:** Not applicable.
- 6.13.6 **Race:** Rose and Peter are of white European origin (no relevant issues identified).
- 6.13.7 **Religion or belief:** There is mention in some IMRs that neither had a religious belief and this has been confirmed by Tina, Peter's daughter (no relevant issues identified).

6.13.8 **Sex:** No relevant issues were identified.

6.13.9 **Sexual orientation:** The couple were heterosexual (no relevant issues were identified).

## General

- 6.14 Peter is described by a neighbour who made a noise nuisance complaint as a “menace”. We know that he had a history of violence towards others (including previous partners). A disclosure of domestic violence with an ex-girlfriend is referenced in the WLMHT IMR. There are also reports of incidents of violence and abuse towards Rose (and her children), towards his own children and also a mental health worker. Although the noise nuisance reports state he was cooperative and compliant when they had contact with him, it is difficult to understand how he generally presented to professionals and whether staff were hesitant about questioning and challenging him about his behaviour and lifestyle.
- 6.15 It is noted that there is a break in Peter’s offending history and this may have coincided with him reporting that he was no longer taking drugs.
- 6.16 A significant gap identified is how Peter’s mental health concerns faded with time and that there was no recognition of his mental health history, (particularly in the GP records) and an absence of considering the potential of safeguarding adults issues. The lack of a diagnostic code being added to his GP records concerning his mental health meant that information about his historical contact with mental health services became lost in the passage of time.
- 6.17 There was a very prompt follow up by the clinic offered to Peter on the day before Rose’s death following concerns raised by Rose about Peter’s mood, and there were measures in place to help monitor any deterioration in Peter’s mental health as a result of possible Peginterferon-induced psychosis. However, the lack of formal verification of Peter’s mental health highlights a gap in the assessment and safeguarding response to patients subject to anti-viral medication who may have previous mental health concerns.
- 6.18 Given that the information about Peter’s mental health was historical, the panel are unable to state whether this information had been shared with the clinic by his GP, if this would have changed his course of treatment if this may have possibly contributed to the events that resulted in Rose’s death.
- 6.19 The review has found that professionals (particularly clinicians across all health services involved in this review), were ill equipped and unskilled to consider and respond to the potential of domestic violence. This is due to a lack of training, policies and procedures to



understand domestic violence and staff being confident to conduct appropriate clinical domestic violence enquiry with both Rose and Peter.

- 6.20 A number of recommendations of this review focus on general practice's response to domestic violence. The recommendations reflect the NICE Guidance (PH50) Domestic Violence and Abuse – how services can respond effectively. It is hoped that the implementation of the NICE domestic violence guidance, combined with the completion of the review's recommendations will help to improve the health element of the local community coordinated response to domestic violence.
- 6.21 The review of the IMRs and chronologies showed no documented evidence of domestic violence enquiry with either Rose or Peter. Despite mention of a partner in both Rose's and Peter's health records, domestic violence is invisible and there was no consideration of the potential risks Peter posed to Rose.

## **Recommendations**

- 7.1 The recommendations made by this review reflect the consistent lack of awareness of the prospect of domestic violence and the overlap with mental health by the services in contact with Rose and Peter. The recommendations also address the safeguarding concerns posed by Peter, both to himself and others. The recommendations are particularly themed on the issue of training staff on awareness of domestic violence and conducting enquiry.
- 7.2 There were missed opportunities to find out more about Rose and Peter's relationship. There was no evidence of domestic violence enquiry being conducted with either Rose or Peter or an exploration of their relationships and support networks. If enquiry is not conducted, the prospect of direct self-disclosure of domestic violence (direct for the person experiencing the abuse) will be minimal.
- 7.3 This review has generated a large number of recommendations. The panel has made several regional and national recommendations to help inform strategic policy development. The panel has not identified a single point of contact which would have prevented Rose's death but have identified missed opportunities when Rose and Peter could have been asked about their relationships and where domestic violence enquiry would have been relevant and helpful.

- 7.4 The review's recommendations are numerous in order to help support the Safer Ealing Partnership understand what parts of the coordinated community response to domestic violence need to be strengthened and improved.
- 7.5 The recommendations are wide ranging and attempt to address direct themes identified in the review as well as associated issues that have an impact on the response to domestic violence by services in Ealing.
- 7.6 All of the agencies involved in this review should audit their practice, policies and procedures and where gaps are identified, ensure that they put in place provision to address staff awareness of domestic violence and their ability to respond appropriately to concerns and disclosures of domestic violence.
- 7.7 An internal action for the WLMHT has already been promulgated to allow learning to occur alongside swift change to organisational change. This is shown below:

**7.7.1 West London Mental Health Trust**

Add to the domestic violence page of the organisation's intranet site, a new section titled Risk Assessment to include the CAADA DASH RIC form.

7.7.2 The intranet site has now been updated and changed to ensure that the borough domestic violence risk assessment tools are easily accessible and visible for staff to locate and use.

7.8 Recommendations made concerning Ealing Hospital's Accident and Emergency Department have been amended to apply to the new Urgent Care Centre. All recommendations will be overseen by the Safer Ealing Partnership, and will be delivered by the Ealing Violence Against Women and Girls Strategic Group. The recommendations have also been translated into an action plan (Appendix 3) which is included at the rear of this report.

7.9 The panel recommendations are shown below:

**7.9.1 Safer Ealing Partnership**

**Recommendation 1**

Widely disseminate learning to services mentioned in this review. This should be in the form of a written briefing to all relevant staff and dissemination session(s).

**Recommendation 2**

Ensure that the circumstances and findings of this review are incorporated into any commissioned domestic violence training delivered in the borough.

**Recommendation 3**

Produce a multi-agency domestic violence referral pathway/protocol in consultation with the Police and specialist domestic violence services and ensure partnership staff are aware of the document through training and publicity.

**Recommendation 4**

Commission a borough domestic violence publicity campaign to include provision of an awareness poster and a palm size/Z card which should be distributed across the partnership to outline to victims the domestic violence support available locally.

7.9.2 **Safer Ealing Partnership (also addressed as a national recommendation for the Home office)**

**Recommendation 5**

Review and address the funding provision to domestic violence support services concerning the support offered to cases that are classed as Police non-crime domestic incidents.

7.9.3 **Safer Ealing Partnership and Ealing Safeguarding Adults Board**

**Recommendation 6**

Work to secure inclusion of vulnerable adults within the evolving borough's Multi Agency Safeguarding Hub.

**Recommendation 7**

Audit adult safeguarding links and information sharing processes between GPs, the Police and mental health services.

**Recommendation 8**

Work with services in the borough who support domestic violence victims, vulnerable adults and carers so that there is an understanding of these agendas and ensure that this is addressed in training.

**Recommendation 9**

Audit referral processes so that agencies working with domestic violence victims, vulnerable adults and carers have effective referral and safeguarding systems to respond to concerns raised by their client groups (such as Multi Agency Risk Assessment Conference, and safeguarding adult alerts).

### **Recommendation 10**

Ensure that the circumstances and findings of this review are incorporated into any commissioned safeguarding and domestic violence training delivered in the borough as well as into any routine audits of safeguarding adults practice. The training should have a specific focus on carer abuse and the dynamics of domestic violence that may feature and also the connection between the use of alcohol, substances, mental health and the incidence of domestic violence.

#### **7.9.4 Ealing Safeguarding Adults Board**

### **Recommendation 11**

Review the process of carer assessments and include domestic violence screening enquiry questions into the process.

#### **7.9.5 Ealing Housing Providers and Registered Social Landlords**

### **Recommendation 12**

Produce a specific housing and domestic violence policy and procedure, to especially detail responding to repairs, noise nuisance reports and making referrals to specialist services.

### **Recommendation 13**

Ensure all staff are trained on the domestic violence policy and procedure.

### **Recommendation 14**

Ensure staff and residents have access to up to date domestic violence information, highlighting services and support available.

#### **7.9.6 Metropolitan Police:**

### **Recommendation 15**

Pilot an assessment criteria, to support and improve consistent decision making and practice when officers are considering making a referral to a specialist domestic violence support service for victims involved in a non-crime domestic.

### **Recommendation 16**

Ensure that there is a follow up for every domestic violence victim where they are seen/contacted and are provided with information on local domestic violence support services (linked to recommendation 4) and that this action is then recorded on CRIS.

#### 7.9.7 **Ealing Noise Nuisance Team**

##### **Recommendation 17**

Ensure that officers responding to noise nuisance or housing related anti-social behaviour complaints are trained on safeguarding vulnerable adults and understand how to identify concerns and make a safeguarding adult alert.

#### 7.9.8 **Ealing Hospital NHS Trust**

##### **Recommendation 18**

Conduct a domestic violence needs analysis to identify and understanding staff training requirements.

##### **Recommendation 19**

Create a Level 2 and 3 safeguarding training package that includes domestic violence so that staff understand their roles and responsibilities.

##### **Recommendation 20**

Raise awareness of the MARAC processes risk assessment tools and referral processes.

##### **Recommendation 21**

Identify and audit DV attendances in the urgent care centre to establish if cases have been managed appropriately, including if they have been provided with information and advice and if the case has been subject to a domestic violence risk assessment.

##### **Recommendation 22**

Explore options of commissioning independent domestic violence advocacy service provision to be located with the urgent care centre.

##### **Recommendation 23**

Implement clinical domestic violence enquiry within the triage system for the urgent care centre.

##### **Recommendation 24**

Scope the opportunity to devise a liaison meeting (reflecting the weekly safety net meeting held to discuss child safeguarding concerns) to share vulnerable adults concerns.

#### 7.9.9 **Ealing's commissioned specialist domestic violence services**<sup>15</sup>

##### **Recommendation 25**

Provide specific training to the Met Police Community Safety Team to include information on the domestic violence referral pathway.

##### **Recommendation 26**

Create and distribute a domestic violence card to be provided to all uniformed Police officers to give to all callers at all non-crime domestics.

##### **Recommendation 27**

Engage in a jointly delivered programme of community engagement activities to raise the profile and promote the domestic violence services available in the borough.

#### 7.9.10 **RISE**

##### **Recommendation 28**

Commission and deliver domestic violence dynamics and domestic violence risk assessment training for all clinical staff.

##### **Recommendation 29**

Implement enquiry for domestic violence as part of intake assessment for all clients (both as victims and perpetrators) and ensure there is a referral pathway in place to specialist domestic violence services for both victims and perpetrators.

#### 7.9.11 **Ealing CCG**

##### **Recommendation 30**

Ensure that the learning points from this review are shared across the CCG partner practices.

##### **Recommendation 31**

CCG Safeguarding Team to work with the GP practice in close proximity to the domestic violence refuge to support their immediate take up of the offer from the refuge service provider of domestic violence training.

##### **Recommendation 32**

Consider how mental health diagnosis and domestic violence issues are coded or flagged within GP records.

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<sup>15</sup> Southall Black Sisters and Hestia Advocacy Service (commissioned by Safer Communities) and Housing for Women and Hestia (Supporting People).

#### 7.9.12 **NHS England (London Area)**

##### **Recommendation 33**

Review the use and effectiveness of the IRIS Project across London GP practices to consider potential for wider commissioning of the project.

#### 7.9.13 **Ealing CCG and General Practice Ealing**

##### **Recommendation 34**

Via the Named GP audit GP compliance with LSCB safeguarding training in Ealing.

##### **Recommendation 35**

To advise Practices to use the Royal College of General Practitioners toolkit which include a domestic violence audit.

##### **Recommendation 36**

Consider ways to commission domestic violence training for GP staff relevant to their roles and responsibilities (doctors, practice nurses and reception staff).

##### **Recommendation 37**

Encourage all GP locations to display and have available up to date information on domestic violence and support services.

#### 7.9.14 **Imperial College Healthcare NHS Trust (St Mary's Hospital)**

##### **Recommendation 38**

When prescribing antiviral medication (such as Peginterferon) which has documented side effects of inducing psychiatric disorders, a specific verification from the patients GP concerning any mental health concerns should be obtained.

##### **Recommendation 39**

Hospital Safeguarding Team to link to Ealing Safeguarding Adults Board and ensure that the Hepatology Clinic has access to information on safeguarding adult process and support services.

##### **Recommendation 40**

Amend the notification letter sent to the GP concerning commencing antiviral treatment to specifically request that if they have any information which may have an impact on the patient to notify the Hepatology Clinic without delay.

#### 7.9.15 **Ealing CCG and Imperial College Healthcare NHS Trust (St Mary's Hospital)**

##### **Recommendation 41**

Arrange a meeting between borough safeguarding GPs and Safeguarding Vulnerable Adults Leads with the Hepatology Clinic to improve partnership working and support offered to patients who are considered vulnerable.

##### **Recommendation 42**

Share information with all Ealing GP's about the Hepatology care pathway so that they are aware and understand their role in the care plan for patients being treated by the Hepatology Clinic.

### **National recommendations**

- 7.10 The panel has made a number of national recommendations to address concerns identified through the review process. It was agreed that although these could not be monitored by the Safer Ealing Partnership it was important to include these so that could provide helpful feedback to the Home Office Quality Assurance Panel to highlight broader strategic and policy issues considered relevant to the review.

#### 7.10.1 **Home Office and Department of Health (national recommendation)**

##### **Recommendation 1A**

Work with NHS England to clarify responsibilities and requirements of commissioning GP IMRs to help resolve issues with delays and quality of GP IMRs submitted to DHRs.

#### 7.10.2 **Department of Health (national recommendation)**

##### **Recommendation 2A**

Seek to rectify the patient information systems used across all clinical settings so that attendances at health care settings can be linked and viewed in their entirety.

#### 7.10.3 **Home Office (national recommendations)**

##### **Recommendation 3A**

Review and address the funding provision to domestic violence support services concerning the support offered to cases that are classed as Police non-crime domestic incidents.



**Recommendation 3B**

Review and improve access to specialist support provision for families affected by domestic homicide, (this should cover step or blended families when the biological parent is the perpetrator).

## Key

CAADA	Co-ordinated Action Against Domestic Abuse
CAD	Computer Aided Dispatch
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CNWL	Central North West London
CRIS	Crime Record Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
CWHHE CCG Collaborative	Central London/West London/Hammersmith and Fulham/Hounslow/Ealing Clinical Commissioning Group Collaborative – representing Ealing CCG.
DASH RIC	Domestic Abuse Stalking Harassment (CAADA risk indicator checklist)
DHR	Domestic Homicide Review
ECIRS	Ealing Children’s Interagency Response Service
EMD	Emergency Medical Dispatcher
Emma	Perpetrators daughter
EOC	Emergency Operations Centre
GP	General Practitioners
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
IRIS Project	Identification and Referral to Improve Safety (GP practice scheme)
Karen	Girlfriend of Peter, reference by WLMHT in 1998
LAS	London Ambulance Service
LSCB	Local Safeguarding Children Board
Luke	Son of victim
MARAC	Multi Agency Risk Assessment Conference
Matthew	Son of victim
MASH	Multi Agency Safeguarding Hub
MPS	Metropolitan Police Service
Paula	Previous partner of Peter
Peter	Perpetrator
Rose	Victim
SEP	Safer Ealing Partnership
STU	Specialist Trained Unit
Tina	Perpetrators daughter
WLMHT	West London Mental Health Trust

# Appendix 1

## Domestic Homicide Review Terms of Reference for Rose

The original terms of reference for the first review were used.

The DHR Panel will consider:

1. Each agency's involvement with the following people between 01/01/1993 and 13/03/2012.
  - 1.1 The panel have agreed that the date of the period covered from the review is significant in length. Agencies have therefore agreed to date the review from 1993 but to only provide a light touch of history dating back to 1993, with attention only specifically to the perpetrators access to mental health services and any issues deemed using professional judgement that could be relevant to the review.
  - 1.2 Case names and relationships:
    - 1.2.1 The victim was Rose
    - 1.2.2 The perpetrator was Peter
    - 1.2.3 Victim's children
      - Matthew
      - Luke
    - 1.2.4 Perpetrator's children
      - Tina
      - Emma.
2. Whether an improvement in any of the following might have led to a different outcome for Rose.
  - 2.1 Communication between services and, in particular, between services in different areas.
  - 2.2 Information sharing between services.
  - 2.3 Joint assessment, decision-making, intervention and monitoring.
3. Whether the support, care and protection work undertaken by services in this case was consistent with each organisation's:
  - 3.1 Professional standards

- 3.2 Domestic violence policy, procedures and protocols in place at the time of the point on the chronology
- 3.3 Whether these standards, policies, procedures and protocols are consistent with current best practice.
- 3.4 Whether staff followed the organisation's existing policy and practice guidance.
4. The response of the relevant agencies to any referrals relating to any of the above named persons, during the period covered by this Review. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:
  - 4.1 Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact within the period covered by this review onwards.
  - 4.2 Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
  - 4.3 Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made.
  - 4.4 The quality of the risk assessments undertaken by each agency in respect of Rose and Peter.
5. The compromises faced by the victim and to make recommendations to avoid a recurrence.
6. Whether there are lessons to be learned for partnership working and service design.
7. Whether thresholds for intervention were appropriately calibrated and applied correctly.
8. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of those involved and whether any special needs were explored, shared appropriately and recorded.
9. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
10. Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

The above terms of reference should be read in conjunction with the statutory guidance for Domestic Homicide Reviews (<http://www.homeoffice.gov.uk/publications/crime/DHR-guidance?view=Binary>)

Panel members should be aware that all DHR proceedings are wholly confidential. Details should not be shared with any non-panel members, including managers and colleagues

without the explicit written permission of the Chair who would normally only grant this in exceptional circumstances. Towards the end of the process, a publicly accessible overview report will be produced containing all the information that will ever enter the public domain via the DHR process. Information not covered within this report will remain confidential in perpetuity.

Please note that these terms of reference were agreed when the original review was instigated. Following the second review process recommencing in May 2013 the panel has agreed to work within the original terms of reference with a slight amendment to the date of the review, regarding a light touch for IMRs and chronologies dating back to 1993.

## Appendix 2

### Panel members and agencies represented

<b>Panel Member</b>	<b>Agency</b>
Simon Boniface	Ealing Council
Nicky Brownjohn	CCG
Alena Buttivant	WLMHT
Aiman Elal	Victim Support
Ray Fallon	Ealing Council
Liz Gaffney	Victim Support
Paul Gardner	Police
Victoria Hill	Standing Together
Bal Kaur	Ealing Council
Ruth Lacey	Ealing Council
Paul Martin	Police
Nev Nolan	Police
Joyce Parker	Ealing Council
Hina Patel	Housing 4 Women
Pragna Patel	Southall Black Sisters
Louise Pavli	RISE
Josh Ryan	LAS
Helen Sweeney-Marcus	Hestia Housing
Lesley Tilson	Ealing Hospital
Edward Ward	NHS England
Sean Yates	Police

## Appendix 3

### Action Plan

All recommendations will be overseen by Safer Ealing Community Partnership and will be delivered by the Ealing VAWG Strategic Group.

<b>Recommendation</b>	<b>Action to take</b>	<b>Lead</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date</b>	<b>Date of completion and outcome</b>
<b>Safer Ealing Partnership</b>					
Prepare a report collating the learning from all reviews to be made available to the partnership	Domestic Abuse event for the Safer Ealing Partnership(SEP) focusing on review recommendations		The SEP have the knowledge to give direction and make decisions on Ealing's response to VAWG in the borough	End of 2015	
Produce a multi-agency domestic violence referral pathway/protocol in consultation with the Police and specialist domestic violence services and ensure partnership staff are aware of the document through training and publicity			Referral pathway completed whilst this review was underway		April 2014
Commission a borough domestic violence publicity campaign to include provision of an awareness poster and a palm size/Z card which should be distributed across the partnership to outline to victims the domestic violence support	Consider development of an app to provide key details. Develop posters for key sites	VAWG Task Group	Resources identified to develop the materials Sub group established from the VAWG Task group to lead on the development of materials	December 2015	

available locally					
<b>Safer Ealing Partnership and the Home Office</b>					
Review and address the funding provision to domestic violence support services concerning the support offered to cases that are classed as Police non-crime domestic incidents	Ensure that numbers are monitored through the service providers VAWG Strategic Group receive performance reports which include this information Relevant Commissioning groups consider this issue as part of their commissioning strategy	VAWG Strategic Group with support from VAWG Task Group		Ongoing monitoring	
<b>Safer Ealing Partnership and Ealing Safeguarding Adults Board</b>					
Work to secure inclusion of vulnerable adults within the evolving borough's Multi Agency Safeguarding Hub.(MASH)	Children and Adults Social Care	MASH Steering Group	Work ongoing regular discussion between Safeguarding Adult Co-ordinator and Safe guarding Children's Services		
Audit adult safeguarding links and information sharing processes between GPs, the Police and mental health services	Adult Social Care Safe Guarding Vulnerable Adults	Safe Guarding Vulnerable Adult Lead	Safeguarding Adults Service manager meets with local lead nurse in Clinical Commissioning Group on a monthly basis discussion includes GP links. Meetings take place with Argyle Road Surgery which provides GP Service to many Care homes Safeguarding Co-	Ongoing	



			ordinator attends bi monthly Safeguarding Clinical Governance for mental health. Safeguarding reps also attend MARAC and MAPPS		
Work with services in the borough who support domestic violence victims, vulnerable adults and carers so that there is an understanding of these agendas and ensure that this is addressed in training	VAWG Task Group & Safeguarding Adults Team	Adult Social Care Training	Develop borough training programme. Training provided by Standing Together offered to MH staff and Adult Social care staff. MSP and DV to be developed and training for staff so that they are confident to work with dv and refer to IDVA services		
Audit referral processes so that agencies working with domestic violence victims, vulnerable adults and carers have effective referral and safeguarding systems to respond to concerns raised by their client groups (such as Multi Agency Risk Assessment Conference, and safeguarding adult alerts)			Representative from Safeguarding attends monthly MARACs		
Ensure that the circumstances and findings of this review are incorporated into any commissioned safeguarding and domestic violence training delivered in the borough as well as into any routine audits of safeguarding adults practice. The					

training should have a specific focus on carer abuse and the dynamics of domestic violence that may feature and also the connection between the use of alcohol, substances, mental health and the incidence of domestic violence					
<b>Ealing Safeguarding Adults Board</b>					
Review the process of carer assessments and include domestic violence screening enquiry questions into the process			Safeguarding Adults Service manager to ensure discussion at next meeting		
<b>Ealing Housing Providers and Registered Social Landlords</b>					
Produce a specific housing and domestic violence policy and procedure, to especially detail responding to repairs, noise nuisance reports and making referrals to specialist services	Review current policies and procedures and update in line with new legislation	Joyce Parker	A working group has been established overseeing the policy development		November 2015
Ensure all staff are trained on the domestic violence policy and procedure			Following the ratification of the housing policy a training programme will be put in place		
Ensure staff and residents have access to up to date domestic violence information, highlighting services and support available			Ealing Councils website is currently being updated		
<b>Metropolitan Police</b>					
Pilot an assessment criteria, to support and improve consistent			This action is being managed at a pan London level by the police		

decision making and practice when officers are considering making a referral to a specialist domestic violence support service for victims involved in a non-crime domestic					
Ensure that there is a follow up for every domestic violence victim where they are seen/contacted and are provided with information on local domestic violence support services (linked to recommendation 4) and that this action is then recorded on CRIS			This action is being managed at a pan London level by the police		
<b>Ealing Noise Nuisance Team</b>					
Ensure that officers responding to noise nuisance or housing related anti-social behaviour complaints are trained on safeguarding vulnerable adults and understand how to identify concerns and make a safeguarding adult alert			Training has already been completed and processes put in place to ensure that vulnerabilities are recognised and appropriate referrals are made		September 2014
<b>Ealing Hospital NHS Trust</b>					
Conduct a domestic violence needs analysis to identify and understanding staff training requirements					
Create a Level 2 and 3 safeguarding training package that includes domestic violence so that staff understand their roles and responsibilities					

Raise awareness of the MARAC processes risk assessment tools and referral processes	Training given to staff by Standing Together who co-ordinate Ealing MARAC	MARAC Co-ordinator	Training has taken place in A&E and other hospital departments	Ongoing	
Identify and audit DV attendances in the urgent care centre to establish if cases have been managed appropriately, including if they have been provided with information and advice and if the case has been subject to a domestic violence risk assessment			Screening for dv is commencing within A&E with the intention to extend into triage system for urgent care		
Explore options of commissioning independent domestic violence advocacy service provision to be located with the urgent care centre.	Trust exploring dependent on resources the model currently available in West Middlesex Hospital		Meeting has taken place with victim Support who provide West Middlesex service.	Dependant on resources being available	
Implement clinical domestic violence enquiry within the triage system for the urgent care centre					
Scope the opportunity to devise a liaison meeting (reflecting the weekly safety net meeting held to discuss child safeguarding concerns) to share vulnerable adults concerns					

<b>Ealing's commissioned specialist domestic violence service</b>					
Provide specific training to the Met Police Community Safety Team to include information on the domestic violence referral pathway		VAWG Task Group	Develop training programme which can be used for police and other partners		
Create and distribute a domestic violence card to be provided to all uniformed Police officers to give to all callers at all non-crime domestics					
Engage in a jointly delivered programme of community engagement activities to raise the profile and promote the domestic violence services available in the borough		Police	Domestic Violence event taking place in February 2015 with police, partners and the community		
<b>RISE</b>					
Commission and deliver domestic violence dynamics and domestic violence risk assessment training for all clinical staff.			Half of the team have received Domestic Violence Training with a further date for the remaining staff still to be booked. The date will be booked by the end of the month to take place as soon as possible		
Implement enquiry for domestic violence as part of intake assessment for all clients (both as victims and perpetrators) and ensure there is a referral pathway in place to specialist domestic violence services for both victims			A referral pathway for perpetrators and victims is in place. Current risk assessment paperwork asks whether individuals are at risk of abuse or a risk to others, but does not explicitly include the term		

and perpetrators			domestic abuse. All assessment paperwork is currently undergoing a review and this will be rectified as part of the changes		
<b>Ealing CCG</b>					
Ensure that the learning points from this review are shared across the CCG partner practices	Safeguarding team to provide a briefing note in the GP bulletin	Ann Coles	Ealing GP's are aware of the risks of DV to adult victims and children	February 2015	
CCG Safeguarding Team to work with the GP practice in close proximity to the domestic violence refuge to support their immediate take up of the offer from the refuge service provider of domestic violence training	Named GP to review learning from the case with the practice	Ann Coles and Tamsin Robinson	Practice is hub for GP DV knowledge	February 2015	
Consider how mental health diagnosis and domestic violence issues are coded or flagged within GP records	Check system one coding systems for DV and mental health	Tamsin Robinson		April 2015	
<b>NHS England (London Area)</b>					
Review the use and effectiveness of the IRIS Project across London GP practices to consider potential for wider commissioning of the project			The NHS are currently reviewing the use of the IRIS project in Ealing		
<b>Ealing CCG and General Practice Ealing</b>					
Via the Named GP audit GP compliance with LSCB safeguarding training in Ealing.	Named GP to design and undertake audit of GP practices training	Tamsin Robinson		April 2015	Referral pathways for GP's have

	compliance				already been completed
To advise Practices to use the Royal College of General Practitioners toolkit which include a domestic violence audit	Toolkit to be sent to practices	Tamsin Robinson		April 2015	
Consider ways to commission domestic violence training for GP staff relevant to their roles and responsibilities (doctors, practice nurses and reception staff)	Link with Hestia and Southall black Sisters to identify possible training packages	Ann Coles		April 2015	
Encourage all GP locations to display and have available up to date information on domestic violence and support services.	Link with Hestia and Southall Black sisters women's group to access material. CCG locality leads to send out information with GP bulletin	Ann Coles		April 2015	
<b>Imperial College Healthcare NHS Trust (St Mary's Hospital)</b>					
When prescribing antiviral medication (such as Peginterferon) which has documented side effects of inducing psychiatric disorders, a specific verification from the patients GP concerning any mental health concerns should be obtained	Clinic to learn from this case and review practices	Hep Clinic	Learning will be identified from the case		
Hospital Safeguarding Team to link to Ealing Safeguarding Adults Board and ensure that the	ICHT to provide assurance that the Hepatology clinic has	Guy Young	Robust measures in place to ensure that the Clinic has appropriate access to	April 2015	Hepatology clinic has access to

Hepatology Clinic has access to information on safeguarding adult process and support services	access to information on safe guarding adult process and support services across the NWL boroughs and what is the compliance rate (last annual figure) of staff in that clinic in relation to safeguarding adults training		safeguarding support and is effective in responding to safeguarding issues		information on the Trust safeguarding adult process and support services this is available on all trust computers through the intranet At October 2014 the safeguarding adults training compliance rate was nursing (100%) and doctors (84%)
Amend the notification letter sent to the GP concerning commencing antiviral treatment to specifically request that if they have any information which may have an impact on the patient to notify the Hepatology Clinic without delay	Trust to develop a letter	ICHT	Information to GP's is robust	Complete	
<b>Ealing CCG and Imperial College Healthcare NHS Trust (St Mary's Hospital)</b>					
Arrange a meeting between borough safeguarding GPs and Safeguarding Vulnerable Adults	ICHT to provide evidence within quarterly safeguarding	Guy Young ICHT	Vulnerable patients will receive joined up care from the clinic and GPs	April 2015 complete	The safeguarding lead for ICHT

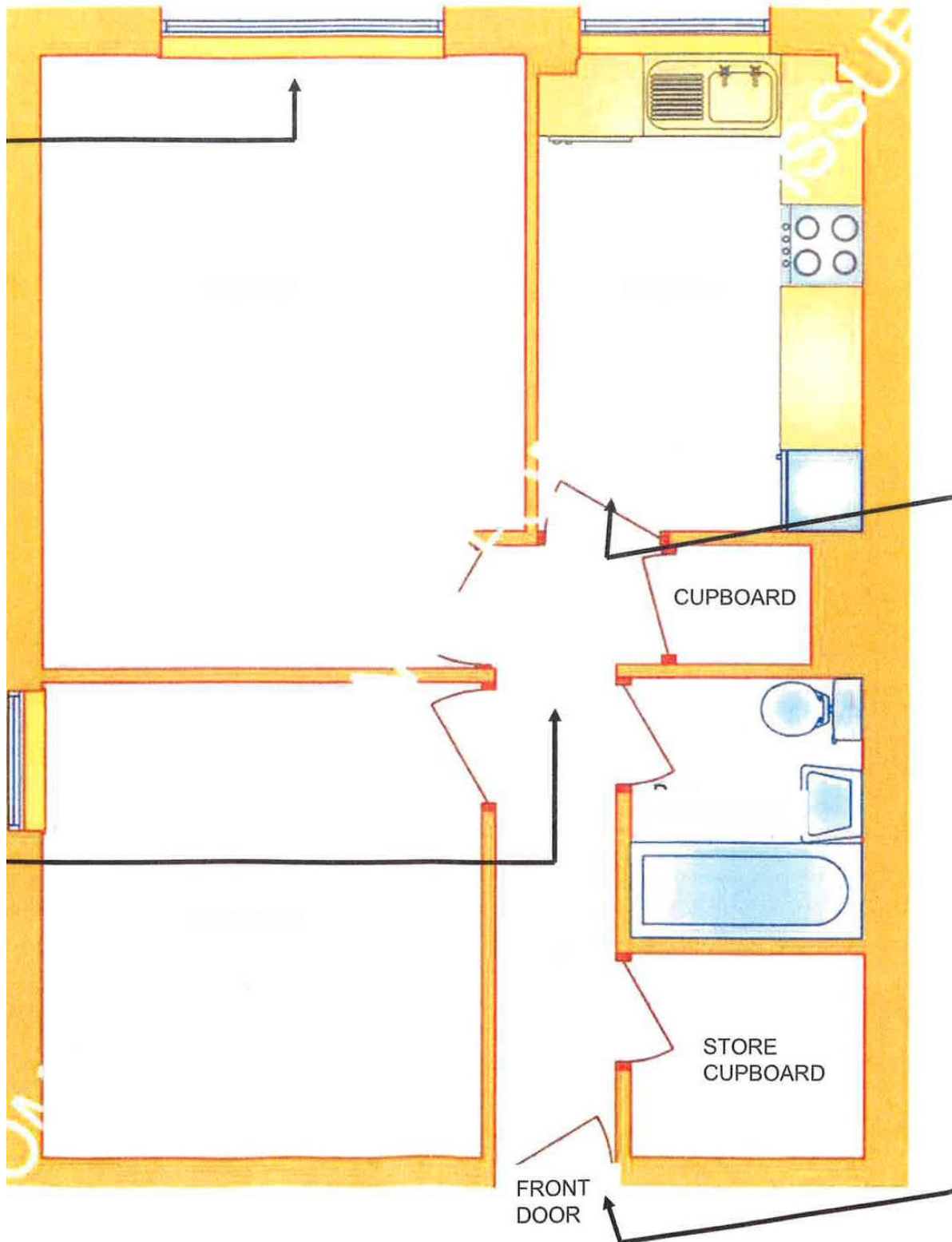


<p>Leads with the Hepatology Clinic to improve partnership working and support offered to patients who are considered vulnerable</p>	<p>report to the CCGs of how the clinic staff review vulnerable patients and liaise with GP's</p>				<p>does not attend the clinic to review vulnerable adult cases but such cases are alerted to the divisional safeguarding lead for discussion and advice as appropriate. The divisional lead reviews all SGA alerts recorded on Datix (incident reporting system) Any identified SGA themes are disseminated through the specialist medicine directorate committee</p>
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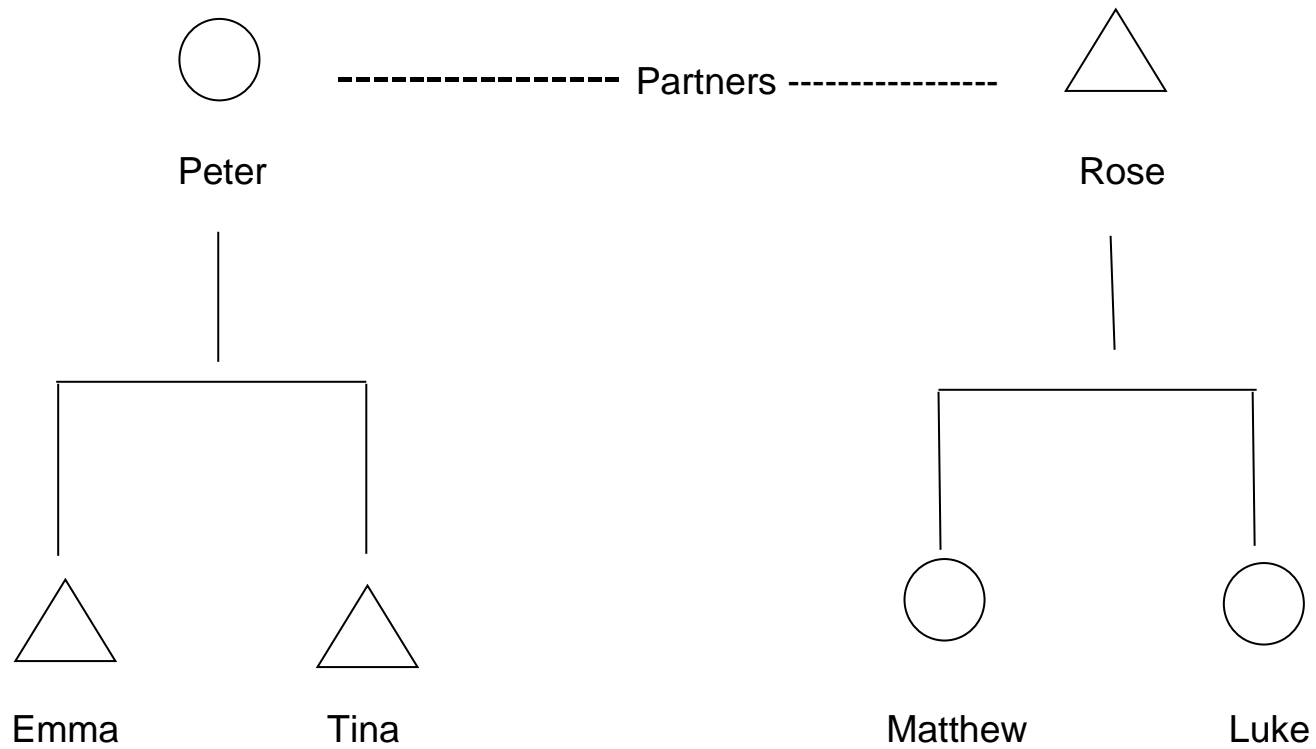
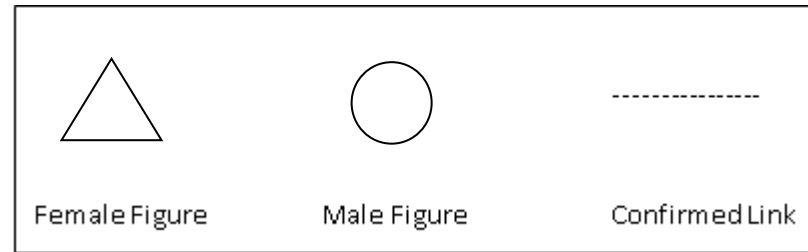
					<p>divisional quality and safety committee and the Turst adult safeguarding committee</p> <p>If there is a vulnerable patient identified through screening process the nurse specialist will liases directly with the GP as is the current practice.</p>
Share information with all Ealing GP's about the Hepatology care pathway so that they are aware and understand their role in the care plan for patients being treated by the Hepatology Clinic.	ICHT to provide evidence within the quarterly safeguarding report to the CCG of information flow to GP's in relation to the Hepatology clinic	Guy Young ICHT	There will be a clear information pathway between the clinic and GP's regarding patients using the clinic	April 2015	

# Appendix 4 – Layout of Peter's property

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## Appendix 5: Genogram



## Appendix 6: Home Office Quality Assurance Panel Response Letter



Home Office

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Road Ealing W5 2HL

23 September 2015

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Dear Ms Parker

Thank you for submitting the Domestic Homicide Review report for Ealing (Rose) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 August 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a diligent and thorough review which demonstrated an excellent understanding of domestic abuse. There was good challenge and probe on information provided to the review and this had resulted in a good set of lessons identified which reflected the content of the review.

There were some aspects of the report which the Panel felt could benefit from further analysis or revision which you may wish to consider before you publish the final report:

- The Panel felt further discussion on the impact of the perpetrator’s personality disorder on his relationship and his behaviour generally may be useful;
- The Panel questioned whether an IPCC review had been conducted given the circumstances of the case;
- The Panel queried whether the conclusion in paragraph 6.7 was speculation or based on medical opinion;
- A potential typing error in paragraph 5.29: should it be “...it would not have been appropriate...”
- Similarly, a potential typing error in the first line of paragraph 7.1: should this be “consistent” rather than “inconsistent”. The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely

Christian Papaleontiou

Chair of the Home Office DHR QA Panel

